

# Phoenix Behavioral Health Services, LLC

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## MEDICATION HISTORY

Client Name: \_\_\_\_\_

Intake Date \_\_\_\_\_

Name of Medication	Date Began	Date Ended	How is medication taken?	Dosage	Prescribing Physician/ Psychiatrist
			<input type="checkbox"/> Topical <input type="checkbox"/> Oral <input type="checkbox"/> Injection	<input type="checkbox"/> 1x daily <input type="checkbox"/> 2x daily <input type="checkbox"/> 3x daily <input type="checkbox"/> 4x daily as needed	
			<input type="checkbox"/> Topical <input type="checkbox"/> Oral <input type="checkbox"/> Injection	<input type="checkbox"/> 1x daily <input type="checkbox"/> 2x daily <input type="checkbox"/> 3x daily <input type="checkbox"/> 4x daily as needed	
			<input type="checkbox"/> Topical <input type="checkbox"/> Oral <input type="checkbox"/> Injection	<input type="checkbox"/> 1x daily <input type="checkbox"/> 2x daily <input type="checkbox"/> 3x daily <input type="checkbox"/> 4x daily as needed	
			<input type="checkbox"/> Topical <input type="checkbox"/> Oral <input type="checkbox"/> Injection	<input type="checkbox"/> 1x daily <input type="checkbox"/> 2x daily <input type="checkbox"/> 3x daily <input type="checkbox"/> 4x daily as needed	
			<input type="checkbox"/> Topical <input type="checkbox"/> Oral <input type="checkbox"/> Injection	<input type="checkbox"/> 1x daily <input type="checkbox"/> 2x daily <input type="checkbox"/> 3x daily <input type="checkbox"/> 4x daily as needed	