MEDICATION AND SUBSTANCE LIST: Please complete for all medications & substances you are taking.

Prescriptions and over-the counter medications

Name	What do you take it for?	How often and when do you take it?	How much / what dose do you take?	How long have you been taking it?	Is it helpful?
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Other: __alcohol __caffeine __nicotine __marijuana/cannabis __other drugs/substances

Name	What do you take it for?	How often and when do you take it?	How much / what dose do you take?	How long have you been taking it?	Is it helpful?
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					