# Key to Health Chiropractic
## Patient Medication & Herb History Form

**Name:**_____Date:_____

| Current Herbs | Prescribed for : | Results since taking it ? | How long taking it ? |
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| Current over the Counter Medication / NSAID's / Antacids /Sleep Aids/ etc | For what? | Results since taking? Side Effects ? | Temporary ? Years ? |
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| Medicine ? | For what ? | Results since taking? Side Effects? | Temporary ? Years ? |
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Allergies?_____

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Have you ever had an adverse reaction to supplements, or medicines ? Yes / No Explain:

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