

Other Providers List

Patient Name: _____ **DOB:** _____

Date: _____

List all healthcare providers who have been involved in your care in the past 2 years. Include conventional medical specialists, dentists, psychotherapists, and all complementary or alternative practitioners.

NOTE: Please contact The Gilbert Clinic (TGC) if you seek consultation or treatment from any new practitioner not listed below prior to starting at TGC or during the program at TGC.

	Provider Name	Address & Phone	Specialty (e.g., Internist, Oncologist, Acupuncturist etc.	Typical Frequency of Visits	Date Last Visit	Date Next Visit, if any
1						
2						
3						
4						
5						
6						
7						
8						
9						

If you need more space, please copy this page or ask us to send you another one.

Current (Baseline) Prescription Medications

(List any non-prescription supplements on a separate form)

Name: _____ DOB: ___/___/_____ Date: ___/___/_____

#	Name of Prescription State reason for use and name of prescribing doctor	Date Started	Current Dose (mg)	How do you take it?
1				<input type="checkbox"/> once daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
2				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
3				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
4				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
5				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
6				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
7				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
8				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
9				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
10				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
11				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
12				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
13				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
14				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
15				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____

Current (Baseline) Non Prescription Supplements

(List any vitamins herbs or natural remedies you are currently using)

Name: _____ DOB: ___/___/___ Date: ___/___/___

#	Name of Supplement - Explain reason for use	Date Started	Current Dose (mg)	How do you take it?
1				<input type="checkbox"/> once daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
2				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
3				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
4				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
5				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
6				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
7				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
8				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
9				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
10				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
11				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
12				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
13				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
14				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____
15				<input type="checkbox"/> one daily <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m. <input type="checkbox"/> one twice daily <input type="checkbox"/> other _____