ALLY Physical Therapy, LLC
2460 Lemoine Avenue Suite 204 Fort Lee, NJ 07024
Tel: 201-742-1114 | Fax: 201-482-8757

Date: ________________

Patient Name: ______________________________ D.O.B. (MM/DD/YYYY): ___________________

Medication List

Please indicate all of your prescription and non-prescription (over the counter) medications:

Medication	Dosage	Frequency	Administration
		__ As needed __ Once a day __ Twice a day __ Three times a day __ Other	__Oral (by mouth) __ Dermal (topical) __ Transdermal (patch) __ Ophthalmic (eye drops) __ Nasal (inhalers) __ Subcutaneous (insulin)
		__ As needed __ Once a day __ Twice a day __ Three times a day __ Other	__Oral (by mouth) __ Dermal (topical) __ Transdermal (patch) __ Ophthalmic (eye drops) __ Nasal (inhalers) __ Subcutaneous (insulin)
		__ As needed __ Once a day __ Twice a day __ Three times a day __ Other	__Oral (by mouth) __ Dermal (topical) __ Transdermal (patch) __ Ophthalmic (eye drops) __ Nasal (inhalers) __ Subcutaneous (insulin)
		__ As needed __ Once a day __ Twice a day __ Three times a day __ Other	__Oral (by mouth) __ Dermal (topical) __ Transdermal (patch) __ Ophthalmic (eye drops) __ Nasal (inhalers) __ Subcutaneous (insulin)
		__ As needed __ Once a day __ Twice a day __ Three times a day __ Other	__Oral (by mouth) __ Dermal (topical) __ Transdermal (patch) __ Ophthalmic (eye drops) __ Nasal (inhalers) __ Subcutaneous (insulin)