Dr. Mary Warren, D.C.

SUBSTANCE SURVEY FORM

Name_____ Date_____

Please list any prescription medications you are currently taking or have taken in the last year.

Medications	Diagnosis

Please list any over-the-counter medications you are currently taking or have taken in the last year.

Product	Symptom	Quantity & Frequency

Please list any vitamins, supplements, herbs, or homeopathic medicines you are currently taking or have taken in the last year: (Use other side if needed).

Product	Symptom	Quantity & Frequency

Check the following items which apply to you and indicate the amount used:

☐ Coffee _____	☐ Artificial Sweetener _____	☐ Ice Cream _____
☐ Tea _____	☐ Antacids _____	☐ Alcohol _____
☐ Soft Drinks _____	☐ Laxatives _____	☐ Cigarettes _____
☐ Diet Drinks _____	☐ Candy _____	☐ Other Tobacco _____

How many desserts do you have in any average week? _____