Christopher Burritt D.O.
Child and Adolescent Psychiatry

Introductory Information

Current medications

Include supplements and over the counter items. Please write the name, when it was started, how it is used (such as "as needed", ever day in the morning, etc) and then describe the effects you have observed whether positive or negative including possible side effects. Use additional pages if needed.

Name: _____ Started: _____ How used: _____

Effects:_____

Name: _____ Started: _____ How used: _____

Effects:_____

Name: _____ Started: _____ How used: _____

Effects:_____

Name: _____ Started: _____ How used: _____

Effects:_____

Prior medications

Name: _____Dates used: _____ How used: _____

Effects and why stopped: _____

_____

Name: _____Dates used: _____ How used: _____

Effects and why stopped: _____

_____

Name: _____Dates used: _____ How used: _____

Effects and why stopped: _____

_____