Medication and Immunization Form

Tigges Chiropractic and Wellness

Name ____ Date __________________

Immunization Record (date of last vaccination)

Flu	Hepatitis
Pneumonia	Tetanus
Other	Other

Allergies (please describe reaction such as hives, throat swelling, GI upset)

Allergic to:

Medications You Are Currently Taking

(including over-the-counter, herbals, patches, nasal sprays, etc.)

If you already have a list, please allow us to copy it.

Medication & Dosage (e.g diphenhydramine, 25mg.	**Directions** (e.g. twice daily, as needed)	**Started taking** **(e.g. 1999)**	**Prescribed by:** **(e.g. Dr. Smith)**