HOGAN CHIROPRACTIC SERVICES

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SUBSTANCE SURVEY FORM

NAME_____ DATE_____

Please list any prescription medications you are taking:

Medications	Diagnosis

Please list any over-the-counter medications you use:

Medications	Symptom	Frequency (Occasional, Often, Daily)

Please list any vitamins, supplements, herbs, or homeopathic remedies (Use other side if necessary)

Supplement	Amount Taken Daily	How long taken

Do you use: Amount Per Day

Coffee _____
Tea _____
Soft Drinks _____
Candy _____
Cigarettes _____
Alcohol _____
Antacids _____

Other Tobacco Products_____

How many desserts do you have in an average week:_____