Supplement List

Page ___ of ___

Client: ____________________________ Date:____________

INSTRUCTIONS: Complete each column, listing your top priority supplements first. In other words, that you feel you cannot live without or symptoms may return or intensify. Supplements are vitamins, minerals, herbs, homeopathics and food supplements. If you are completing this list as a continuation from the Client Information form, please put Page 2 of 2 for the first of the pages you print of this form, then 3 of 3, etc. Otherwise, if this is the first time you have completed this form, put Page 1 of (number of pages you are completing at this time). Note: For **TYPE**, put Vitamin, Mineral, Herb, Homeopathic or if a combination, for example, put Vitamin + Herbs, or Vitamin + Minerals. **STRENGTH** is for example, .5 mg., indicate **DOSAGE** as follows: 1X3 means one pill taken three times daily.

NAME OF SUPPLEMENT	PURPOSE FOR TAKING	TYPE	STRENGTH AND DOSAGE	DATE STARTED Approximate Date is OK	NAME OF COMPANY AND PRACTITINER, IF LATTER APPLIES
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

www.AdvancedClinicalNutrition.com **Email:** stsp@advancedclinicalnutrition.com

(940) 761-4045 Copyright 1996 Donna F. Smith, Ph.D.