**Dr Stephanus P. E. Boshoff D.C.** **Dr. Carisa S. E. Novak D.C.**

**BOSHOFF CHIROPRACTIC CENTER**

# 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 taken 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** | **Amount taken daily** | **How long taken** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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

- ❑ Coffee_____
- ❑ Tea _____
- ❑ Soft Drinks _____
- ❑ Artificial Sweetener _____
- ❑ Antacids _____
- ❑ Laxatives _____
- ❑ Candy _____
- ❑ Ice Cream _____
- ❑ Alcohol _____
- ❑ Cigarettes _____
- ❑ Other Tobacco Products _____

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

1100 W GONZALES ROAD, SUITE 101,OXNARD,CA. 93036.TEL(805)485-4339 FAX(805)485-6042