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**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 taking 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	Symptom	Quantity & Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Coffee	<input type="checkbox"/>	Artificial Sweetener	<input type="checkbox"/>	Ice Cream	<input type="checkbox"/>
Tea	<input type="checkbox"/>	Antacids	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	Laxatives	<input type="checkbox"/>	Cigarettes	<input type="checkbox"/>
Diet Soft Drinks	<input type="checkbox"/>	Candy	<input type="checkbox"/>	Other Tobacco Products	<input type="checkbox"/>

How many desserts do you have in an average week? \_\_\_\_\_