Delson Institute
FOR WELLNESS

Substance Survey

Name_____ Date_____

Please list any 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 _____	☐ Artificial Sweetener _____	☐ Ice Cream _____
☐ Tea_____	☐ Antacids_____	☐ Alchohol_____
☐ Soda_____	☐ Laxatives_____	☐ Cigarettes_____
☐ Diet Soda_____	☐ Candy_____	☐ Tobacco_____

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

Are you willing to take supplements? _____ Are you willing to change your diet? _____