

Delson Institute for Wellness

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Tel- 310-392-6050 Fax- 310-392-6055

SUBSTANCE SURVEY FORM

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:

- | | | |
|--|---|---|
| <input type="checkbox"/> 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"/> Soda _____ | <input type="checkbox"/> Laxatives _____ | <input type="checkbox"/> Cigarettes _____ |
| <input type="checkbox"/> Diet Soda _____ | <input type="checkbox"/> Candy _____ | <input type="checkbox"/> Tobacco _____ |

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

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