NAME: _____ DATE: _____

AFTER your report consult with Dr. Brouse, record Supplement(s)/ RX, Strength/ Dosage, Test/ Re-Test Date(s). At your one month appointment fax or bring this for follow up. This will help assist you on your program. Please call SSHC with any questions (503) 654-3225.

Supplement/ RX	Strength/ Dosage	Test/ ReTest	Test/ ReTest	Test/ ReTest	Test/ ReTest

SPECIAL NOTES: