Medication Symptom Form

CHILD'S NAME:_____ DATE:_____

PERSON COMPLETING FORM:_____

MEDICATION AND DOSE:_____

Please rate each behavior 0 to 5. Circle only one number beside each item.
0 means that you have not seen the behavior in this child during the past week
1 means the symptom has gotten much better in the past month
2 means the symptom has gotten a little better in the past month
3 means that there has been no change in the past month
4 means this symptom has been getting worse in the past month
5 means this symptom has been getting MUCH worse in the past month

Symptom	No Problem	Much Better	Little Better	No Change	Worse	Much Worse
Insomnia or trouble sleeping	0	1	2	3	4	5
Nightmares	0	1	2	3	4	5
Staring a lot or daydreaming	0	1	2	3	4	5
Talking less with others	0	1	2	3	4	5
Decreased appetite	0	1	2	3	4	5
Irritability	0	1	2	3	4	5
Uninterested in others	0	1	2	3	4	5
Stomachaches	0	1	2	3	4	5
Headaches	0	1	2	3	4	5
Drowsiness	0	1	2	3	4	5
Sadness/Unhappiness	0	1	2	3	4	5
Prone to Cry	0	1	2	3	4	5
Anxiousness	0	1	2	3	4	5
Euphoric/unusually happy	0	1	2	3	4	5
Dizziness	0	1	2	3	4	5
Tics or nervous movements	0	1	2	3	4	5

Comments:

_____

_____

_____

_____

_____