Treatment Update Form

Name: _____ **Date:** _____

Please complete before each medication visit

Circle how many days you've felt well in the past week (mentally & physically)

0 1 2 3 4 5 6 7 days

Circle any sleep problems you've had in the past week

1: falling asleep 2: staying asleep 3: waking too early

Next, rate how you've felt over the past week...

	None	**Mild** (infrequent or rarely causes a problem)		**Moderate** (often or causes some problems)		**Severe** (constant or causes many problems)	
Depression, including lack of pleasure/motivation	0	1	2	3	4	5	6
Inactive, withdrawing or not doing much	0	1	2	3	4	5	6
Trouble making decisions, concentrating, planning or organizing	0	1	2	3	4	5	6
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3	4	5	6
Anxiety, fear, or nervousness	0	1	2	3	4	5	6
Irritable, impatient, or argumentative	0	1	2	3	4	5	6
Energized, agitated, restless, wired; or still active despite few hours of sleep	0	1	2	3	4	5	6
More hyper, driven, active, or doing a lot more than normal for you	0	1	2	3	4	5	6
Doing things that others might think are risky, impulsive or excessive	0	1	2	3	4	5	6
Rapid thoughts that move so fast it's hard to follow them	0	1	2	3	4	5	6
Difficulty sustaining attention (e.g. reading, lectures, conversation, TV)	0	1	2	3	4	5	6
Distracted by noises around you or by your own thoughts	0	1	2	3	4	5	6
Procrastinating, avoiding tasks, or not finishing them	0	1	2	3	4	5	6

Circle recent symptoms (regardless of their cause) **Current Weight:** _____

Mental: 1) emotional numbing 2) paranoid sensations 3) panic attacks (how many per week ___?) 4) Hearing voices or seeing things 5) tired 6) memory problems **Sleep:** 7) needing > 10 hr sleep 8) needing < 4 hr sleep 9) vivid dreams 10) sleep-walking 11) snoring **Neurologic:** 12) inner tension or restlessness 13) muscle stiffness 14) slowing or weakness in muscles 15) unwanted muscle movements (besides tremor) 16) imbalance 17) dizziness 18) fainting or falling 19) tremor 20) sensory changes 21) taste changes 22) headaches 23) teeth grinding **General:** 24) flu-like feelings 25) sexual difficulties 26) physical pain (rate 1-10, 10=worst: _____) **Eyes:** 27) blurry vision 28) visual changes 29) double vision **Stomach:** 30) increased appetite 31) binging or purging 32) appetite loss 33) stomach pain 34) nausea 35) diarrhea 36) constipation 37) dry mouth 38) excess thirst 39) excess salivation **Skin:** 40) rash 41) acne 42) excess sweating 43) itch 44) easily sunburned 45) unusual bruising 46) hair loss **Heart:** 47) palpitations **Urinary:** 48) frequent urination 49) difficulty urinating **Female:** 50) menstrual changes 51) breast changes

Caffeine ___ cups/day. Nicotine ___ pack/day. Alcohol: ___ drinks/day. Other drugs since last visit? _____

Sleep meds: ___ #/week. If taking any meds as-needed for anxiety, how many do you use? _____ per: DAY / WEEK / MONTH

Thank you for completing this. These ratings improve medication decisions (in one study they doubled recovery rates!). If you are taking new meds, or are missing doses of your psych meds, please let us know on the back ☺.