Treatment Update (child/adolescent) **Name:** ______________ **Date:** ________

Please complete before each visit that involves medication treatment

In the past week, how many days did feel well (mentally & physically)? _____

In the past week did you have any of these sleep problems (circle):
1: falling asleep 2: staying asleep 3: waking too early

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

	None	**Mild** (infrequent or rarely causes a problem)		**Moderate** (often or causes some problems)		**Severe** (constant or causes many problems)	
I feel down, sad or don't enjoy things	0	1	2	3	4	5	6
My motivation is low and I don't do very much	0	1	2	3	4	5	6
It's hard to think, make decisions or concentrate in school	0	1	2	3	4	5	6
I feel like I'd be better off dead	0	1	2	3	4	5	6
I'm too nervous or worried	0	1	2	3	4	5	6
I get too angry (How did the anger come out?Through words: ☐, Physically with objects: ☐, Physically with people: ☐)	0	1	2	3	4	5	6
I feel real energized, driven to do a lot or don't need much sleep	0	1	2	3	4	5	6
Other people notice that I'm real happy or hyperactive	0	1	2	3	4	5	6
Other people think I'm doing too much or acting impulsive/irresponsible	0	1	2	3	4	5	6
My thoughts move so fast that it's hard to follow them	0	1	2	3	4	5	6
It's hard to pay attention (e.g. at school, reading or watching TV)	0	1	2	3	4	5	6
I'm easily distracted by sounds or by my own thoughts	0	1	2	3	4	5	6
I have trouble starting or finishing my chores or work	0	1	2	3	4	5	6

Circle any symptoms you recently had (regardless of their cause)**:** **Current Weight:** _________

Mental: 1) no emotions 2) thinking others are out to get me 3) panic attacks (how many per week ___?) 4) Hearing voices or seeing things 5) sleepy 6) memory problems **Sleep:** 7) needing more than 10 hr sleep 8) needing less than 4 hr sleep 9) vivid dreams 10) sleep-walking 11) snoring **Neurologic:** 12) muscle restlessness 13) muscle stiffness 14) moving in slow motion 15) muscle twitches 16) difficulty with balance 17) dizzy 18) fainting or falling 19) shaking 20) sensory changes 21) taste changes 22) headaches 23) teeth grinding **General:** 24) flu-like feelings 26) physical pain (rate 1-10, 10=worst: _____) **Eyes:** 27) blurry vision 28) visual changes 29) double vision **Stomach:** 30) hungry a lot 31) overeating or throwing up food 32) not very hungry 33) stomach pain 34) nausea 35) diarrhea 36) constipation 37) dry mouth 38) too thirsty 39) drooling **Skin:** 40) rash 41) acne 42) sweating too much 43) itching 44) easily sunburned 45) unusual bruising 46) hair loss **Heart:** 47) heart pounding **Urinary:** 48) peeing a lot 49) trouble peeing **Female:** 50) changes in menstruation 51) breast changes

Caffeine ___ cups/day. Nicotine ___ pack/day. Alcohol: ___ drinks/day. Other drugs since last visit? _____________
Sleep meds: ___ #/week. If taking an anxiety-med as needed, how many do you use? _____ per day / week / month

If you have had health changes, medication changes, or are taking your psychiatric medicines differently than prescribed please describe that on the back. Thank you ☺