This page requires 2 decisions for each question:

1.) Circle **all symptoms** the patient has experienced in the past month.
2.) **Rate each behavior:** on a 0-10 severity scale. Mark 0 (for absent) to 10 (very serious or frequent).

________ Decreased appetite
________ Trouble sleeping
________ Nausea
________ Vomiting
________ Stomach aches
________ Weight loss
________ Headaches
________ Mood changes
________ Irritability
________ Chest pain
________ Shortness of breath
________ Fainting spells
________ Dizziness

________ Acting unusual/in own world
________ Loss of spark
________ Motor tics/noises
________ Biting/picking at nails
________ Pulling out hair/eye lashes
________ Uninterested in others
________ Seems unusually happy
________ Talks less with others
________ More rapid speech
________ Anxious
________ More drowsy
________ Sad/prone to crying
________ Depressed

________ Often loses temper
________ Often argues with adults
________ Deliberately annoys people
________ Is angry and resentful
________ Is spiteful or vindictive
________ Actively defies or refuses a requests or rules
________ Blames others for his/her n or misbehavior
________ Is touchy/easily annoyed by
________ Aggressive to people or ani
________ Deliberately destroys prope
________ Is deceitful or has stolen ite
________ Has had serious violations

1.) What time does the medicine wear off?______________________________________
2.) Is the medicine helping as much, or less, than last month?________________________
3.) Does your child complain about taking medication or seem to avoid use?_________
4.) Is administration of meds a problem?______________

Since the last visit, please list any important stresses that may have affected your child:

____

What **SUCCESSES** have you experienced since our last visit?

____

Please list medication(s) you have been giving regularly to this child over the past month:

Medicine	√ **Refill needed**	**Dose**	**Time of Da**

reviewed by____ date____________________

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