



Side Effects Monitoring Form

Student Name: _____

Date: _____

Person completing this form: _____

Please rate each possible symptom on two scales. The first refers to seriousness: 0 (not present at all) to 10 (very serious.) The second refers to frequency: 0 (never seen at all) to 10 (present all the time.)

Items:

Disturbed sleep	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
Decreased appetite	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
Weight loss	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
Weight gain	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
Anxiety/excessive worry	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
Irritable	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
Crying	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
Sad/unhappy	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
Biting fingernails/skin picking	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
Stomach aches	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
Unusually happy	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
Dizziness	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
Tics or repetitive, movements	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
Drowsiness	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10

Please return this form to your prescribing physician at your review consultation.