ADHD MEDICATION SIDE EFFECTS MONITORING SHEET

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Have you had any of the following side effects over the last 1 to 2 weeks? **Please circle the side effect of concern when given several options e.g. dry eyes / mouth / skin.

NAME: ______________________ DATE: ______________________ dd / mm / yyyy

Medication name: ______________________ Dose: ______________________

Other psychiatric medication: ______________________

Dose: ______________________

Headache

0 1 2 3 4 5

Dizziness

0 1 2 3 4 5

Thirst

0 1 2 3 4 5

Rash

0 1 2 3 4 5

Sweating

0 1 2 3 4 5

Dry Mouth / Eyes / Skin

0 1 2 3 4 5

Acne

0 1 2 3 4 5

Increase / Decrease appetite

0 1 2 3 4 5

Weight Loss / Gain

0 1 2 3 4 5

Stomach ache

0 1 2 3 4 5

Nausea / Vomiting

0 1 2 3 4 5

Urination Difficulty / Frequency

0 1 2 3 4 5

Tics

Restlessness /Agitation

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Have to keep moving

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Irritability

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Anger

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Sadness

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Fearful /Anxious

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Mood instability / Rapid mood changes

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Mood change when medication wears off (rebound)

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Sleep difficulty

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Sexual functioning issues

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Suicidal ideation

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Other

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Check the box beside the words that best describe your overall level of functioning since your last visit

- ◯ Much worse
- ◯ A little worse
- ◯ No change
- ◯ A little better
- ◯ Much better

Clinician Comments

BP: ______________________ **Pulse:** ______________________