

Antipsychotic Monitoring Form

for children and adolescents

Name : _____ Start Date: _____ Weight: _____ kg Height: _____ cm
 Medication Name: _____ Rater's Name: _____ Relationship to child: _____
 (If different from above)

Purpose: If you have been given this form, it may mean you will be taking an antipsychotic medication to help you decrease your symptoms of a thought disorder (psychosis), schizophrenia, tic disorder or another condition. This form is designed to help you, your caregivers, and your doctor or care team monitor how well your medication is working and any side effects. Please bring this form with you when you visit your doctor to help guide discussions. **For example, use it to point out which symptoms and side effects bother you the most.**

Directions: Use this form to rate possible symptoms and side effects. Please use the blank rows to add any specific symptoms or side effects you want to monitor. Provide a rating before you start taking the antipsychotic (at "baseline") and at the end of each week listed below, whether you see your doctor or not. In the appropriate box, write the **number (0 to 3)** that best describes your experience on average over the past week.

0= Not present (I have not noticed this)	1= A little (It does not bother me)	2= A moderate amount (It bothers me)	3= A severe amount (It bothers me a lot)
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Date								
Dose								

Symptoms	Baseline	1 week	2 weeks	3 weeks	4 weeks	6 weeks	8 weeks	12 weeks
Hallucinations								
Delusions								
Disorganized thoughts								
Aggression								
Hyperactivity								
Low mood								
Anxiety								
Tics (uncontrolled motor movements or vocalizations)								
Disruptive behaviours								
Trouble falling or staying asleep								
Feeling overly excited or happy								

0= Not present
(I have not noticed this)

1= A little
(It does not bother me)

2= A moderate amount
(It bothers me)

3= A severe amount
(It bothers me a lot)

Possible Side Effects	Baseline	1 week	2 weeks	3 weeks	4 weeks	6 weeks	8 weeks	12 weeks
Appetite loss								
Constipation								
Diarrhea								
Disruption with either menstrual cycles or sexual functioning								
Dry mouth								
Feeling agitated								
Feeling dizzy or Lightheaded								
Feeling nauseated or vomiting								
Feeling drowsy								
Headaches								
Increased appetite								
Racing heart beat								
Skin rash								
Stiff muscles								
Urinary problems								
Weight gain								
Weight loss								
Blood work?								
Approximate # of missed doses of your antipsychotic (in the past week)	Not Applicable							

Please list any other medications you are taking: _____
