Treatment Update

Name _____ **Date** _____

Please complete before each medication visit

Over the ***past week*** have you had problems with…	Not at all	Mild		Moderate		Severe	
Depression, low energy/motivation, or lack or pleasure?	0	1	2	3	4	5	6
Anxiety, nervous, or excessive worry?	0	1	2	3	4	5	6
Irritable, agitated, angry, quick to argue?	0	1	2	3	4	5	6
Trouble falling or staying asleep?	0	1	2	3	4	5	6
Poor concentration, attention, or distractibility?	0	1	2	3	4	5	6

Feeling like people are plotting against you, trying to hurt you, or spying on you?	NO	YES	MAYBE
Hearing or seeing things that other people don't?	NO	YES	MAYBE
Have you wished you were dead or wished you could go to sleep and not wake up?	NO	YES	MAYBE
Have you made plans or taken steps toward suicide?	NO	YES	MAYBE

How many times in the past MONTH did you have 4 or more alcoholic drinks a day (for a woman) or 5 or more alcoholic drinks a day (for a man)?

Never ▪ 1-2 times/month ▪ Weekly ▪ Several days a week ▪ Nearly every day

How many times in the past MONTH did you use recreational drugs or prescription drugs for nonmedical reasons?

Never ▪ 1-2 times/month ▪ Weekly ▪ Several days a week ▪ Nearly every day

Any physical symptoms that are bothering you?

Restlessness? Tremor? Tired? Unwanted muscle movements? Dry mouth? Sexual problems?

WEIGHT	NICOTINE USE?

New health problems? New medications? Or taking your psych meds differently than prescribed?

Thank you!