Treatment Update Form

Name: _____ **Date:** _____

Please complete before all visits involving medication treatment

In the past week, how many days did feel well (mentally & physically)? _____

In the past week did you have any of these sleep problems (circle):
1: FALLING ASLEEP 2: STAYING ASLEEP 3: WAKING TOO EARLY

Next, rate how you've felt over past week...

	None	**Mild** (infrequent or rarely causes a problem)		**Moderate** (often or causes some problems)		**Severe** (constant or causes many problems)	
Depression, including lack of pleasure/motivation	0	1	2	3	4	5	6
Inactive, withdrawing or not doing much	0	1	2	3	4	5	6
Trouble making decisions, concentrating, planning or organizing	0	1	2	3	4	5	6
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3	4	5	6
Anxiety, fear, or nervousness	0	1	2	3	4	5	6
Irritable (check if it was: verbal ☐, physical to objects ☐, physical to people ☐)	0	1	2	3	4	5	6
Unusually high energy / motivation or decreased need for sleep	0	1	2	3	4	5	6
Feeling so good or hyper that it was noticeable to others	0	1	2	3	4	5	6
Doing things others might think are risky, impulsive or excessive	0	1	2	3	4	5	6
Rapid thoughts that move so fast it's hard to follow them	0	1	2	3	4	5	6
Difficulty sustaining attention (e.g. reading, lectures, conversation, TV)	0	1	2	3	4	5	6
Distracted by noises around you or by your own thoughts	0	1	2	3	4	5	6
Procrastinating, avoiding tasks or not finishing them	0	1	2	3	4	5	6

Circle if you recently had any of these symptoms: **Current Weight:** _____

Mental: 1) emotional numbing 2) paranoid sensations 3) panic attacks (how many per week ___?) 4) Hearing voices or seeing things 5) fatigue 6) memory problems **Sleep:** 7) needing > 10 hr sleep 8) needing < 4 hr sleep 9) vivid dreams 10) sleep-walking 11) snoring **Neurologic:** 12) inner tension or restlessness 13) muscle stiffness 14) slowing of movements or muscles 15) unwanted muscle movements (besides tremor) 16) imbalance 17) dizziness 18) fainting or falling 19) tremor 20) sensory changes 21) taste changes 22) headaches 23) teeth grinding **General:** 24) flu-like feelings 25) sexual difficulties 26) physical pain (rate 1-10, 10=worst: _____) **Eyes:** 27) blurry vision 28) visual changes 29) double vision **Stomach:** 30) increased appetite 31) binging or purging 32) appetite loss 33) stomach pain 34) nausea 35) diarrhea 36) constipation 37) dry mouth 38) excess thirst 39) excess salivation **Skin:** 40) rash 41) acne 42) excess sweating 43) itch 44) easily sunburned 45) unusual bruising 46) hair loss **Heart:** 47) palpitations **Urinary:** 48) frequent urination 49) difficulty urinating **Female:** 50) menstrual changes 51) breast changes

Caffeine ___ cups/day. Nicotine ___ pack/day. Alcohol: ___ drinks/day. Other drug-use since last visit: _____

Sleep meds: ___ #/week. If taking an anxiety-med as needed, how many do you use? _____ per day / week / month.

If you have had health changes, medication changes, or are taking your psychiatric medications differently than prescribed please describe that on the back. Thank you ☺