Treatment Update Form

Name: _____ **Date:** _____

Please complete before each medication visit

Circle how many days you've felt well in the past week

0 1 2 3 4 5 6 7 days

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

	None	**Mild** (infrequent or rarely causes a problem)		**Moderate** (often or causes some problems)		**Severe** (constant or causes many problems)	
Depression: Low energy, motivation, or lack or pleasure	0	1	2	3	4	5	6
Anxiety: Fear, worry, nervousness	0	1	2	3	4	5	6
Thoughts that life is not worthwhile (circle 5 or 6 if you have thoughts of planning suicide or took action towards it)		Only thoughts of worthlessness		Suicidal thoughts		Plans	Acts
	0	1	2	3	4	5	6
Irritability: Impatient, angry, quick to argue	0	1	2	3	4	5	6
Hyper: Energized, agitated, restless, or doing a lot more things than usual	0	1	2	3	4	5	6
Impulsive: Doing things that are risky or that you might regret (overspending, aggressive driving, suddenly making major life changes)	0	1	2	3	4	5	6
Trouble making decisions	0	1	2	3	4	5	6
Procrastinating or avoiding tasks	0	1	2	3	4	5	6
Easily distracted or difficulty sustaining attention	0	1	2	3	4	5	6
Feeling like other people are out to get you	0	1	2	3	4	5	6
Hallucinations: Hearing or seeing things that other people don't	0	1	2	3	4	5	6
Obsessions (disturbing thoughts, doubts, or images that intrude on your mind) or **Compulsions** (checking, sorting, or cleaning things repeatedly)	0	1	2	3	4	5	6

Circle recent symptoms (regardless of their cause) **Current Weight:** _____

Mental: 1) emotional numbing 2) panic attacks (how many per week ___?) 3) tired 4) memory problems

Sleep: 5) trouble falling asleep 6) trouble staying asleep 7) oversleeping 8) nightmares 9) sleep-walking 10) snoring

Neurologic: 11) inner tension or restlessness 12) muscle stiffness 13) slowing or weakness in muscles 14) tremor 15) other unwanted muscle movements (besides tremor) 16) imbalance 17) dizziness 18) fainting or falling 19) taste changes 20) headaches 21) teeth grinding **General:** 22) flu-like feelings 23) sexual difficulties 24) physical pain (rate 1-10: _____) 25) short of breath 26) racing heart 27) swelling **Eyes:** 28) blurry vision 29) double vision 30) other visual changes **Stomach:** 31) low appetite 32) high appetite 33) binging on food 34) purging to get rid of food 35) stomach pain 36) nausea 37) diarrhea 38) constipation 37) dry mouth 38) very thirsty 39) too much salivation

Skin: 40) rash 41) acne 42) sweating too much 39) itch 40) easily sunburned 41) unusual bruising 42) hair loss

Urinary: 43) urinating too much 44) difficulty urinating **Female:** 45) menstrual changes 46) breast changes

Caffeine ___ cups/day. Nicotine ___ pack/day. Alcohol ___ drinks/day. Other drugs since last visit? _____

Sleep meds: ___ #/week. If taking any meds as-needed for anxiety, how many do you use? _____ per: DAY / WEEK / MONTH

Thank you for completing this. These ratings improve medication decisions (in one study they doubled recovery rates!). If you are taking new meds, or are missing doses of your psych meds, please let us know on the back ☺.