MEDICATION EFFECTS RATING SCALE

NAME: _____ **COMPLETED BY:** _____

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** _____ **GRADE:** _____

DATE FORM COMPLETED: **SITUATION(S):** ❑ **School** ❑ **Home** ❑ **Other:**

MEDICATION	DOSAGE	TIMES ADMINISTERED / DAY

MARK ANY CHANGES NOTICED IN THE FOLLOWING BEHAVIORS:

CHILD'S BEHAVIOR	DO NOT KNOW	NEVER A PROBLEM	BEHAVIOR WORSE	BEHAVIOR NO CHANGE	IMPROVED A LITTLE	IMPROVED A LOT
Attention to task						
Listening to lessons						
Finishing assigned classwork						
Impulsive						
Calling out in class						
Organizing work						
Over activity						
Restless, fidgety						
Talkative						
Aggressive						
Peer interaction						
Sitting Still						
Following directions - homework, etc.						
Argue - talking back						
Doing chores						
Bedtime						
While in car						
Mealtimes						
Washing and bathing						
In public places-restaurants, stores						
Getting dressed / undressed						

COMMENTS: (Continue on back if needed)

MARK ANY SIDE EFFECTS WHICH YOU HAVE NOTICED OR WHICH THE CHILD HAS MENTIONED:

❑ Appetite loss	❑ Sleep disturbed	❑ Headaches	❑ Stomach aches
❑ Seems tired	❑ Stares a lot	❑ Irritability	❑ Excessive crying
❑ Motor / vocal tic	❑ Nervousness	❑ Sadness	❑ Withdrawn

COMMENTS: (Continue on back if needed)