Stimulant Drug Side Effects

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Patient Name ______________________________ Date ____________

Person Completing This Form ______________________________

Medication ______________________________

Instructions
- For each behavior, circle **exactly one number** on the scale.
- 0 means you have **not noticed** the behavior in the past week.
- 9 means (1) you **have noticed** the behavior in the past week, and (2) you believe the behavior occurs **very frequently** or is **very serious**.

Example This means you've **not noticed** anxiety in the past week.

Anxious (0) 1 2 3 4 5 6 7 8 9

Behavior	Absent									Serious
Insomnia or trouble sleeping	0	1	2	3	4	5	6	7	8	9
Nightmares	0	1	2	3	4	5	6	7	8	9
Stares a lot or daydreams	0	1	2	3	4	5	6	7	8	9
Talks less with others	0	1	2	3	4	5	6	7	8	9
Uninterested in others	0	1	2	3	4	5	6	7	8	9
Decreased appetite	0	1	2	3	4	5	6	7	8	9
Irritable	0	1	2	3	4	5	6	7	8	9
Stomachaches	0	1	2	3	4	5	6	7	8	9
Headaches	0	1	2	3	4	5	6	7	8	9
Drowsiness	0	1	2	3	4	5	6	7	8	9
Sad or unhappy	0	1	2	3	4	5	6	7	8	9
Prone to crying	0	1	2	3	4	5	6	7	8	9
Anxious	0	1	2	3	4	5	6	7	8	9
Bites fingernails	0	1	2	3	4	5	6	7	8	9
Euphoric or unusually happy	0	1	2	3	4	5	6	7	8	9
Tics or nervous movements	0	1	2	3	4	5	6	7	8	9

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