Kids Clinic – Post-Medication Form

Child's Name: _____ DOB: _____

Medication (if applicable): _____ Rater's Name: _____

Relationship to Child: _____ Date:_____

This form should be completed **in 2-3 months or before your next visit**. It helps compare changes in your child's focus, behavior, mood, sleep, and any side effects since starting medication. Please record your accurate observations, as this information helps your clinician assess the impact of the medication and whether any further adjustments may be needed. Bring the completed forms to your next appointment or send copies to your paediatrician for review.

Disclaimer: Please include as much details as possible in the **comments section** for each item. Specific examples and notes about when behaviors or side effects occur **(such as time of day or during certain activities)** are very helpful in understanding your child's response to medication.

Rating Scale (0–3)

Score	Description
0	Not present – did not occur this week
1	Mild – occurred rarely and did not interfere with daily life
2	Moderate – noticeable and occasionally disruptive
3	Severe – frequent or significantly disruptive to functioning

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Section 1: Behavioral/Mental Health and Functioning

Symptom	Description	Rating (0-3)	Comments / Notes
Inattention	Difficulty focusing, easily distracted		
Hyperactivity	Restless, unable to sit still		
Impulsivity	Acts before thinking, blurts out		
Emotional Reactivity	Big emotional responses to small problems		
Defiance / Noncompliance	Refuses to follow instructions		
Aggression	Verbal or physical outbursts		
Anxiety / Worry	Appears nervous, tense, or worried		

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Low Mood / Irritability	Sadness, frustration, or withdrawal		
Sleep Difficulties	Trouble falling asleep or staying asleep		
Appetite Changes	Noticeable change in eating habits		
Task Completion	Trouble finishing school or home tasks		

Section 2: Side Effects

Symptom	**Description**	**Rating (0-3)**	**Comments / Notes**
Headaches	Frequent or intense headaches		
Stomach Pain / Nausea	Upset stomach or vomiting		
Appetite Loss / Weight Change	Noticeable changes in appetite or weight		

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Tics / Repetitive Movements	Eye blinking, facial twitches, or repetitive motions		
Sleep Problems	Trouble falling asleep or staying asleep		
Irritability / Agitation	More easily annoyed or restless		
Dizziness / Fatigue	Appears dizzy, weak, or tired		
Dry Mouth / Thirst	Complains of dry mouth or excessive thirst		
Constipation / Diarrhea	Any noticeable digestive changes		
Skin Rash / Allergic Reaction	New rash or sensitivity		

Additional Notes