

**Side Effects Questionnaire
Parent Interview**

Child's Name: _____ Today's Date: _____

Parent's Name(s): _____ Parent's Phone: _____

Name of Current **Medication** and **Dosage** child is taking: _____

Child's Date of Birth: _____

Has your child experienced any of the following side effects or problems in the past week?

None – 0
Circle below

Mild – 1

Moderate – 2

Severe - 3

	0	1	2	3
Headache	0	1	2	3
Stomachache	0	1	2	3
Change of appetite – explain below	0	1	2	3
Trouble sleeping	0	1	2	3
Irritability in the late morning, late afternoon, or Evening – explain below	0	1	2	3
Socially withdrawn – decreased interaction with others	0	1	2	3
Extreme sadness or unusual crying	0	1	2	3
Dull, tired, listless behavior	0	1	2	3
Tremors/feeling shaky	0	1	2	3
Repetitive movements, tics, jerking, twitching, Eye blinking – explain below	0	1	2	3
Picking at skin or fingers, nail biting, lip or cheek Chewing – explain below	0	1	2	3
Sees or hears things that aren't there	0	1	2	3

Any concerns at all, regarding depression or suicidal thoughts or tendencies? Yes / No

Explanations / Comments: