Medication Effects Rating Scale:
Children & Adolescents

N·P·S
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Client Name: ______________________________ Date Today:__________ Rater__________________

Med Name:___________________ Date Started _________, mg: ___ Time taken: ________ am____pm____

Time med wears off:_________ (i.e. appetite returns, loss of focus & motivation, cannot finish tasks, distracted, hyper)

Booster Name: ________________ Date Started _________, mg: ___ Time taken: ________ am____pm____

Time med wears off: _________ MD Prescribing _____________________ Next appt. time: ______________

Behavioral Changes Observed: What Have You Noticed?	Do Not Know	Worse	No Change	A little Better	Much Better	N/A
1. Making better grades/passing subjects						
2. Finishes homework better/completes with less difficulty/sticks to it better						
3. Pays attention better in class						
4. Participates better in class						
5. Obeys school rules better						
6. Gets along better with siblings and/or friends – less sibling conflict						
7. More alert/more awake in class						
8. Wakes up/gets going more easily in the morning						
9. Listens better when adults talk – parents/teachers/coaches, etc.						
10. Obeys adults better/more cooperative/talks back less						
11. Less easily distracted						
12. Less forgetful / better memory						
13. Less irritable/angry/aggressive/agitated						
14. Less impulsive – either verbally or behaviorally						
15. Less easily frustrated – greater tolerance for stress & demands						
16. Less restless/fidgety/overactive						
17. Increased motivation & productivity/procrastinates less						
18. Less talkative or more talkative (circle which one)						
19. Less argumentative						
20. More even moods, less ups and downs						

Rebounding: ___ No ___ Yes Effects: (irritable, angry, sad) ________________________

Time Starts: ____ pm Time Ends: ____ pm

Appetite loss: Brkfst________________ Lunch:______________Dinner:_______________

Sleep problems: ____________ Headaches: _____ Stomach aches:_____more tired: ______

Irritable/Aggressive:_____ Vocal or motor tics:_____ Sadness or depression:_______

Nervousness/Anxiety:_____ Caffeine:________ If yes, how much? ______

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