Psychotropic Medication Side Effects Tracking Sheet

Client Name:

			Drugs(s):															Month:					Year:									
	Side Effects Observed:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Nervousness																														i T	
	Headache																														1	
	Drowsiness																														1	
	Sweating																														1	
	Fever																														1	
	Constipation																														1	
	Vomiting																														1	
	Nausea																														1	
	Diarrhea																														1	
	Decreased appetite																														1	
	Dry mouth																														1	
	Confusion																														1	
	Abnormal Gait																														1	
	Neck stiffness																														1	
	Cough																															
	Rash																															
	Anxiety																															
	Insomnia																														1	
	Manic behavior																														1	
	Muscle pain/spasm																														1	
	Aggressiveness																														1	
	Flu like symptoms																														1	
	Dizziness																														1	
	Fatigue																														1	
	Lightheadedness																														1	
																															1	
	No side effects observed																															
Initials																																

Place 'X' in box when side effect is observed.

ARIF

Signature/Initial:

Initial at bottom daily to acknowledge tracking.

If Physician specifies additional side effects to monitor that are not listed, add it to the form in the space provided.