Side Effects Rating Scale

Child's Name: _____ Date: _____

Person Completing the Form:_____

Please rate each behavior from 0 (absent) to 9(serious). A 0 means that you have not seen this behavior in the past week and a 9 means you have noticed it and believe it is very serious or occurs very frequently.

Behavior	Absent									Serious
Insomnia	0	1	2	3	4	5	6	7	8	9
Nightmares	0	1	2	3	4	5	6	7	8	9
Stares/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/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/unusually happy	0	1	2	3	4	5	6	7	8	9
Dizziness	0	1	2	3	4	5	6	7	8	9
Tics or nervous movements	0	1	2	3	4	5	6	7	8	9