



## Update Since Last Behavioral Health Appointment

*Please fill out the following questionnaire prior to each medication monitoring appointment.*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_  
Primary Care Provider (PCP) who manages medication(s): \_\_\_\_\_  
Current medication(s) and dose(s): \_\_\_\_\_  
Therapist Name: \_\_\_\_\_ Not currently \_\_\_\_\_ Not yet \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ 504 or IEP \_\_\_\_\_  
Private support/tutoring: No Yes

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Overall how do you feel you or your child is doing?

At goal

Improved but needs to fine tune the following

Not well

Are doses missed? Never Sometimes Often

Are you worried about any medication side effects?

No

I'm not worried, but we see the following side effect(s)

Yes, I'm worried about

Please provide a brief update on the following areas:

- School:
- Homework:
- Social:
- Home:
- Appetite/Diet:
- Sleep:
- Mood:
- Safety:

Is there anything else you want to discuss at your appointment?

Are there any forms you would like your provider to fill out at this visit?

No Yes, I will submit them before or bring them to the appointment