

Teacher's Name: \_\_\_\_\_ Class Time: \_\_\_\_\_ Class Name/Period: \_\_\_\_\_  
 Today's Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Grade Level: \_\_\_\_\_

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

**For Office Use Only**

Total Symptom Score for questions 1-18: \_\_\_\_\_

Average Performance Score: \_\_\_\_\_

Please return this form to: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Fax number: \_\_\_\_\_

**FLORIDA PHYSICIANS**  
 MEDICAL GROUP  
 JOSEPH J. KEELEY, MD, FAAP  
 DIPLOMATE, AMERICAN BOARD OF PEDIATRICS  
 PAM BADZINSKI, ARNP  
 THE CENTER FOR CHILD DEVELOPMENT  
 615 E. PRINCETON, SUITE 401 • ORLANDO, FLORIDA 32803  
 407-898-6005 • FAX 407-898-7722