

Client ID # \_\_\_\_\_

Date of Administration: \_\_\_\_\_

# MEDICATION SIDE EFFECTS AND TREATMENT ADHERENCE

## CLIENT SELF-ADMINISTERED

### Adherence Estimator®

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**For each question, please select the response that best describes how you feel about the medicine you are currently taking.**

- 1. I am convinced of the importance of my prescription medicine.**
  - Agree completely
  - Agree mostly
  - Agree somewhat
  - Disagree somewhat
  - Disagree mostly
  - Disagree completely
  
- 2. I worry that my prescription medicine will do more harm than good to me.**
  - Agree completely
  - Agree mostly
  - Agree somewhat
  - Disagree somewhat
  - Disagree mostly
  - Disagree completely
  
- 3. I feel financially burdened by my out-of-pocket expenses for my prescription medicine.**
  - Agree completely
  - Agree mostly
  - Agree somewhat
  - Disagree somewhat
  - Disagree mostly
  - Disagree completely