MEDICATION SIDE EFFECTS AND TREATMENT ADHERENCE

CLIENT SELF-ADMINISTERED OR CLINICIAN-ADMINISTERED

1. **Do you currently take any prescription medications?**
   - Yes
   - No → *Skip Q2*
   - Unsure/Don’t know → *Skip Q2*

2. **What side effects do you currently experience from your medication?**
   Check all that apply.
   - Daytime sedation/ drowsiness/ sleeping too much
   - Problems with memory or concentration
   - Changes in appetite or weight
   - Muscles being too tense or still, or muscles trembling or shaking
   - Feeling restless, jittery, or the need to move around and pace
   - Blurry vision, dry mouth, constipation, or urinary retention or hesitancy
   - Changes in sexual functioning
   - Problems with menstruation or breast problems (women only)
   - Feeling unlike usual self
   - Other (Specify: ________________)
   - None