SIDE EFFECTS RATING SCALE

Child's Name: _____ Date:_____

Person completing this form: _____

Instructions: Please rate each behavior from 0 (absent) to 9 (serious). Circle only one number beside each item. A 0 means that you have not seen the behavior in this child during the past week, and a 9 means that you have noticed it and believe it to be either very serious or occur very frequently.

Behavior	Absent									Serious
Insomnia or trouble sleeping	0	1	2	3	4	5	6	7	8	9
Nightmares	0	1	2	3	4	5	6	7	8	9
Stares a lot or 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