## ANTIDEPRESSANT MONITORING TOOL

**NAME:** _______________________________________  **Age:** ______  **Informant:**______________________________

**ANTIDEPRESSANT:**_______________________________________  **Psych. Dx:**______________________________

**Medical Dx/Concerns:**

### Other Medications

<table>
<thead>
<tr>
<th>Other Medications</th>
</tr>
</thead>
</table>

### TARGET SYMPTOMS

<table>
<thead>
<tr>
<th>Target Symptoms (rate over past week)</th>
<th>* Rating 0-3</th>
<th>Target Symptoms (rate over past week)</th>
<th>* Rating 0-3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient</td>
<td>Informant</td>
<td>Patient</td>
</tr>
</tbody>
</table>

### SIDE EFFECTS (SE) OVER THE PAST WEEK:

#### PATIENT REPORT:

<table>
<thead>
<tr>
<th>SE Rating</th>
<th>Patient</th>
<th>Informant</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Patient Report:

- Nausea
- Feeling Unsteady
- Sleep Problems
- Vomiting
- Dizziness / Faint
- Feel Tense / Nervous
- Change in Appetite
- Tremor
- Restlessness/Agitation
- Change in Weight
- Confused/disoriented
- ↑ Hyper / Excitable
- Stomach Pain
- Foggy Head/Spaced Out
- ↑ Irritability
- Diarrhea
- Heart Beating Fast
- Hostility
- Constipation
- Heart Pounding
- ↑ Mood Swings
- Dry Mouth
- Numbness / Tingling
- ↑ Suicidal Ideation
- Blurred Vision
- Leg Spasms At Night
- Trouble Urinating
- Headaches
- ↑ Sweating
- ↓ Interest In Sex
- Daytime Drowsiness
- Skin Rash
- Erectile Problem
- Muscle Weakness
- Fatigue / Lethargy
- ↓ Orgasm/Ejaculation

**Notes:**

### SAFETY

<table>
<thead>
<tr>
<th>Non-compliance</th>
<th>Suicide Ideation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insight</td>
<td>Suicide Intent</td>
</tr>
<tr>
<td>Substance Use</td>
<td>Suicide Plan</td>
</tr>
</tbody>
</table>

**Notes:**

* Symptom Rating: 0 = Absent 1 = Present / not problematic 2 = Problematic / Ø impairment 3 = Problematic / + impairment

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PHYSICAL EXAM: Weight: ____________ Height: ____________ HR: ___________ BP: ___________

CLINICAL CHANGE RATING
Rate change since last assessment based on patient, informant and clinician impression (-2 to +2)
-2: much worse  -1: little worse  0: no change  +1: little better  +2: much better

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>PATIENT RATING</th>
<th>INFORMANT RATING</th>
<th>CLINICIAN RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYMPTOMS</td>
<td>-2  -1  0  +1  +2</td>
<td>-2  -1  0  +1  +2</td>
<td>-2  -1  0  +1  +2</td>
</tr>
<tr>
<td>SIDE EFFECTS</td>
<td>-2  -1  0  +1  +2</td>
<td>-2  -1  0  +1  +2</td>
<td>-2  -1  0  +1  +2</td>
</tr>
<tr>
<td>SCHOOL/WORK FUNCTION</td>
<td>-2  -1  0  +1  +2</td>
<td>-2  -1  0  +1  +2</td>
<td>-2  -1  0  +1  +2</td>
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<tr>
<td>FAMILY FUNCTION</td>
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<td>-2  -1  0  +1  +2</td>
<td>-2  -1  0  +1  +2</td>
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<tr>
<td>PEER FUNCTION</td>
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<td>-2  -1  0  +1  +2</td>
<td>-2  -1  0  +1  +2</td>
</tr>
<tr>
<td>RECREATION FUNCTION</td>
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<td>-2  -1  0  +1  +2</td>
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<tr>
<td>SAFETY</td>
<td>-2  -1  0  +1  +2</td>
<td>-2  -1  0  +1  +2</td>
<td>-2  -1  0  +1  +2</td>
</tr>
<tr>
<td>SUMMARY (since last assessment)</td>
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<td>-2  -1  0  +1  +2</td>
<td>-2  -1  0  +1  +2</td>
</tr>
</tbody>
</table>

OVERALL IMPROVEMENT RATING: Patient/Informant/Clinician Overall Rating Since Initiation of Intervention or Mental Health Contact:
-2  -1  0  +1  +2  -2  -1  0  +1  +2  -2  -1  0  +1  +2

Notes:______________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Plan:________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

PRESCRIPTION:__________________________________________________________ # Refills ________
Pharmacy tele:____________________________ F/U: DATE/TIME: __________________________

ASSESSMENT COMPLETED BY: ___________________________ DATE: _____________________________

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Signature: ____________________________________________