BRANCHES COUNSELING CENTER
Recovering Hope • Restoring Lives

MENTAL HEALTH MEDICATION MANAGEMENT FOLLOW UP FORM

Name: _____ DOB: _____ Date: _____

Please list any changes to your contact information since last visit: _____

Please list any changes to your medications since your last visit:_____

Please list any specific concerns that you would like to discuss today: _____

_____

Please indicate how often you've experienced the following symptoms since your last visit by circling the numbers:

Symptoms	Not at all	Several days	More than half the days	Nearly every day
feeling down, depressed, or hopeless	0	1	2	3
little interest or pleasure in doing things	0	1	2	3
trouble falling or staying asleep, or sleeping too much	0	1	2	3
feeling tired or having little energy	0	1	2	3
poor appetite or overeating	0	1	2	3
feeling bad about yourself or that you are a failure	0	1	2	3
trouble concentrating on things	0	1	2	3
moving or speaking very slowly or being more fidgety and restless than usual	0	1	2	3
thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
feeling nervous, anxious, or on edge	0	1	2	3
not being able to stop or control worrying	0	1	2	3
worrying too much about different things	0	1	2	3
trouble relaxing	0	1	2	3
being so restless that it is hard to sit still	0	1	2	3
becoming easily annoyed or very irritable	0	1	2	3
feeling afraid as if something awful might happen	0	1	2	3
feeling so good or hyper people thought you weren't your normal self	0	1	2	3
thoughts raced through your head or trouble slowing down your mind	0	1	2	3
feeling much more self-confident than usual	0	1	2	3
got much less sleep than usual but didn't miss it or need it	0	1	2	3
more talkative or spoke faster than usual	0	1	2	3
much more social or outgoing than usual	0	1	2	3
did things unusual for you that others thought were excessive or risky	0	1	2	3
How difficult have these symptoms made it to function lately?	Not at all difficult	Somewhat difficult	Very difficult	Extremely difficult