NAME: _____ **Date:** _____

FOLLOW UP QUESTIONNAIRE

Please complete this form 1-3 days prior to your scheduled appointment and upload into the Patient Portal. Your response allows Dr. Bayliss to focus the visit on your most pressing and relevant concerns instead of using up valuable time for routine screening questions. Your responses will be evaluated by Dr. Bayliss and entered as part of the medical record. These responses will be used to track the overall progress of treatment. Forms must be submitted **PRIOR TO** the start of your follow-up appointment to be reviewed by Dr. Bayliss. Thank you for completing this symptom assessment in advance. You are the most valuable member of the treatment team.

Name: _____ **Date**: _____

1. Since the last appointment, have any of the following occurred?
Please check all that apply or select "none of the above" at the bottom

- ☐ Major life changes (e.g. relationships, work, housing)
- ☐ Medical illness or changes to medications
- ☐ Emergency room visit or hospital admission
- ☐ Self injury (eg. Cutting, burning, head banging)
- ☐ Suicide attempt
- ☐ Significant alcohol use (3+ drinks in one day)
- ☐ Use of illicit or street drugs (including marijuana/THC)
- ☐ None of the above

If any of the above events occurred, please describe: _____

_____

_____

_____

_____

_____

_____

2. Have any of the following symptoms occurred in the past 1-2 weeks? (check all that apply)

- ☐ Fever/chills
- ☐ Poor appetite
- ☐ Heat/cold intolerance
- ☐ Visual changes
- ☐ Hearing loss/tinnitus
- ☐ Palpitations
- ☐ Cough/wheezing
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Frequent urination/urgency
- ☐ Rash
- ☐ Easy bruising
- ☐ Muscle/joint pain or swelling
- ☐ Tremors/shaking
- ☐ Headaches
- ☐ Numbness/tingling
- ☐ None of the above

3. In general, how do you feel about your/their medications?

- ☐ Happy and would like to keep them the same
- ☐ Want to talk about changing them because they are not helping enough
- ☐ Want to talk about changing them because of side effects
- ☐ Other:

4. How often do you/they miss a dose of medications?

- ☐ Never
- ☐ 1-2 times a month
- ☐ 1-2 times a week
- ☐ 3+ times a week

5. Are you/they having any medication side effects? ☐ **No** (skip to #7) ☐ **Yes**

6. Medication side effects:

	Mild (a little)	Moderate (somewhat)	Severe (very)
Sleepiness/drowsiness	☐	☐	☐
Dizziness	☐	☐	☐
Headaches	☐	☐	☐
Nausea or feeling sick to stomach	☐	☐	☐
Constipation	☐	☐	☐
Dry mouth	☐	☐	☐
Blurry vision	☐	☐	☐
Tense or jerky muscles	☐	☐	☐
Increased appetite or weight gain	☐	☐	☐
Sexual side effects	☐	☐	☐

6a. Other medication side effects: _____

Psychiatric Symptoms:

7. On average, how would you/they rate **daily mood**? (**0**=very low, sad, depressed, **5**=neutral, "OK" mood, **10**= unusually good, silly, manic, elevated)

8. How bothersome has **depression** been on a scale of 0-10? (**0**=not at all, **10**=extremely bothersome)

9. How bothersome has **anxiety/worry** been on a scale of 0-10? (**0**=not at all, **10**=extremely bothersome)

10. How would you describe your/their **energy level/activity** on a scale of 0-10? (**0**=extremely low, **5**="just right", **10**=very high)

11. How would you describe your/their **sleep** on most nights? (check all that apply)

- ☐ Restful, refreshing
- ☐ Not enough
- ☐ Toss and turn all night
- ☐ Too much
- ☐ Wake up numerous times
- ☐ Trouble falling asleep
- ☐ Wake up too early
- ☐ Nightmares
- ☐ Night tremors/sleep walking
- ☐ Other: _____

12. During the **past 2 weeks**, how often (if ever) have the following symptoms occurred?

	Never	Rarely (1-2x/month)	Sometimes (1-2x/week)	Often (almost daily)
More angry than usual or lost temper	☐	☐	☐	☐
Little interest/enjoyment of usual activities	☐	☐	☐	☐
Difficulties concentrating/forgetfulness	☐	☐	☐	☐
Flashbacks	☐	☐	☐	☐
Hearing voices or seeing shadows/images that others didn't	☐	☐	☐	☐
Feeling paranoid	☐	☐	☐	☐

Safety concerns: Since your last appointment, how often (if ever) have you:

	Never	Rarely (1-2x/month)	Sometimes (1-2x/week)	Often (almost daily)
Feeling that life is not worth living	☐	☐	☐	☐
Thoughts about suicide	☐	☐	☐	☐
Desire to engage in self-injurious behaviors	☐	☐	☐	☐
Thoughts about killing another person	☐	☐	☐	☐

Reviewed by Physician _____ Date: _____