RECORD OF TREATMENT EMERGENT SYMPTOMS (ROTES)

PATIENT NAME:_____DATE: _____

Please check any items that are a problem as mild (a bit of a nuisance), moderate (a definite problem) or severe (major difficulty). **Put a tic in the box for those items that *are* a problem.**

				This shaded portion will be completed by a clinician during your next appointment				
				Relationship to drug			Drug(s) responsible	
Difficulty	**Mild**	**Mod**	**Sev**	**Not likely**	**Possible**	**Probable**		
1. Trouble falling asleep								
2. Waking at night								
3. Waking up early								
4. Nightmares								
5. Shows less emotion								
6. Rebound*								
7. Aggression								
8. Lack of spontaneity								
9. Not eating								
10. Decreased appetite								
11. Irritable/cranky								
12. Angry								
13. Stomach aches								
14. Headaches								
15. Tired during the day								
16. Sad/unhappy								
17. Thoughts of Death								
18. Suicidal Threats								
19. Suicidal Attempts								
20. Crying								
21. Anxious or worried								
22. Bites Fingernails								
23. Picking								
24. Overly happy								
25. Dizziness								
26. Nauseous								
27. Vomiting								
28. Constipation								
29. Rash								
30. Mood swings								
31. Jittery or nervous								
32. Dry Mouth								
33. Sexual Dysfunction								
34. Difficulty urinating								
35. Blinking								
36. Repeated movemen								
37. Throat clearing/noise								
38. Other:								
39. Other:								

*Rebound means the child is worse when medication is wearing off, with increased irritability, reactivity or anger