Client ID # ______________________________ Date of Administration: ____________________________

MEDICATION SIDE EFFECTS AND TREATMENT ADHERENCE

CLINICIAN-ADMINISTERED

Brief Adherence Rating Scale (BARS)

1. **[OPTIONAL] How many pills of *[name of antipsychotic]* did the doctor tell you to take each day?**

   ____

2. **[OPTIONAL] Since your last visit with me, on how many days did you NOT TAKE your *[name of antipsychotic]*?**
   - ○ Few, if any (<7)
   - ○ 7-13
   - ○ 14-20
   - ○ Most (>20)

3. **Since your last visit with me, how many days did you TAKE LESS THAN the prescribed number of pills of your *[name of antipsychotic]*?**
   - ○ Never/almost never (0%-25% of the time)
   - ○ Sometimes (26%-50% of the time)
   - ○ Usually (51%-75% of the time)
   - ○ Always/almost always (76%-100% of the time)

4. **[OPTIONAL] Please place a single vertical line on the dotted line below that you believe best describes, out of the prescribed antipsychotic medication doses, the proportion of doses taken by the client in the past month.**