EPINET
Early Psychosis Intervention Network

Client ID # _____ Date of Administration: _____

MEDICATION SIDE EFFECTS AND TREATMENT ADHERENCE

CLIENT SELF-ADMINISTERED OR CLINICIAN-ADMINISTERED

1. Do you currently take any prescription medications?

- ○ Yes
- ○ No → ***Skip Q2***
- ○ Unsure/Don't know → ***Skip Q2***

2. What side effects do you currently experience from your medication?

Check all that apply.

- ☐ Daytime sedation/ drowsiness/ sleeping too much
- ☐ Problems with memory or concentration
- ☐ Changes in appetite or weight
- ☐ Muscles being too tense or still, or muscles trembling or shaking
- ☐ Feeling restless, jittery, or the need to move around and pace
- ☐ Blurry vision, dry mouth, constipation, or urinary retention or hesitancy
- ☐ Changes in sexual functioning
- ☐ Problems with menstruation or breast problems (women only)
- ☐ Feeling unlike usual self
- ☐ Other (Specify: _____)
- ☐ None