MEDICATION ASSESSMENT FORM

PATIENT NAME: **DATE:**

CONDITION: _____

SCALE: 1 (Dissatisfied) 2 (quite dissatisfied) 3 (undecided) 4 (quite satisfied) 5 (satisfied)
N/A (not applicable/does not apply to you)

MEASURE	**SCALE**					
DESIRED SYMPTOM CONTROL	1	2	3	4	5	N/A
PAIN	1	2	3	4	5	N/A
MUSCULAR SPASM	1	2	3	4	5	N/A
BLADDER/BOWEL SPASM	1	2	3	4	5	N/A
APPETITE	1	2	3	4	5	N/A
WEIGHT CHANGE	1	2	3	4	5	N/A
MOBILITY	1	2	3	4	5	N/A
TREMORS	1	2	3	4	5	N/A
ANXIETY	1	2	3	4	5	N/A
DEPRESSION	1	2	3	4	5	N/A
DROWSINESS	1	2	3	4	5	N/A
NAUSEA	1	2	3	4	5	N/A
SLEEP/NIGHTMARES	1	2	3	4	5	N/A
UNUSUAL EXPERIENCES/LETHARGY/SLEEPINESS	1	2	3	4	5	N/A
SEIZURE FREQUENCY	1	2	3	4	5	N/A
SOCIAL INTERACTION	1	2	3	4	5	N/A
OVERALL SATISFACTION	1	2	3	4	5	N/A

DOCTORS USE ONLY:

ALERTNESS	**BP**	**PR**	**RESP**	**WEIGHT**	**GAIT**	**TREMOR**	**TONE**	**DTR**