STIMULANT SIDE EFFECT CHECKLIST

Child's Name: _____ Date: _____
Name of Person Completing This Form: _____

Instructions: Please rate each behavior from 0 (absent) to 9 (serious). CIRCLE ONLY ONE NUMBER BESIDE EACH ITEM. A zero means that you have not seen this behavior in your child during the past week; and 9 means that you have noticed it, and believe it either to be very serious or to occur very frequently. Thank you.

Behavior:	Absent									Serious
Insomnia or trouble sleeping	0	1	2	3	4	5	6	7	8	9
Nightmares	0	1	2	3	4	5	6	7	8	9
Stares a lot or daydreams	0	1	2	3	4	5	6	7	8	9
Talks less with others	0	1	2	3	4	5	6	7	8	9
Uninterested in others	0	1	2	3	4	5	6	7	8	9
Decreased appetite	0	1	2	3	4	5	6	7	8	9
Irritable	0	1	2	3	4	5	6	7	8	9
Stomachaches	0	1	2	3	4	5	6	7	8	9
Headaches	0	1	2	3	4	5	6	7	8	9
Drowsiness	0	1	2	3	4	5	6	7	8	9
Sad/unhappy	0	1	2	3	4	5	6	7	8	9
Prone to crying	0	1	2	3	4	5	6	7	8	9
Anxious	0	1	2	3	4	5	6	7	8	9
Bites his or her nails	0	1	2	3	4	5	6	7	8	9
Euphoric/unusually happy	0	1	2	3	4	5	6	7	8	9
Dizziness	0	1	2	3	4	5	6	7	8	9

From: Hyperactive Children by Russell Barkley, Ph.D.