

Scale of Improvement and Impact of Medication Side Effects.

Carer's opinion of improvement for the child while taking this medication. Carer's opinion of the level of impact to the child daily functioning, due to medication side effects.

* Required

1. Please select the number which best describes the level of improvement or not, of your child since commencing this medication. *

Compared to before taking this medication.

	1. Very much Improved	2. Much Improved	3. Minimally improved	4. No change	5. Minimally worse	6. Much worse	7. Very much worse
Level of improvement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Please select the number, in your judgement, which best describes the impact of any side effects experienced by your child while taking this medication. *

	1. None	2. Do not significantly interfere	3. Significant interference	4. Side effects outweighs medication benefits
Side effects impact on daily life for you child	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Please select the number, in your judgement, which best describes the impact of any side effects experienced by your child while taking this medication. *

	1. None	2. Do not significantly interfere	3. Significant interference	4. Side effects outweighs medication benefits
Side effects impact on daily life for you child	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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