

Month _____ Year _____ Weight _____

SAMPLE FORM

Lana Castle 2019
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Prescription & OTC Meds		Dose	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Mood stabilizer(s)		mg	2	2	2	2	2	2	2																								
Antipsychotics(s)		mg	2	2	2	1	1	1	1																								
Antianxiety agent(s)		mg	3	3	3	3	3	3	3																								
Antidepressant(s)		mg	2	2	2	2	2	2	2																								
Other medication(s)		mg	1	2	1	1	1	1																									
Vitamin(s)/mineral(s)		mg	1	1	1	1	1	1	1																								
OTC (over-the-counter) meds		mg		1	1	1																											
Alcohol		oz	1	1		1																											
Nicotine			5	5	4	5	3	3	2																								
Illicit drugs																																	
Lifestyle	Nighttime sleep	hr/min	8.5	9	9	8	8	8	8																								
	Daytime sleep/nap(s)	hr/min	1 hr	.5 hr	.5 hr																												
	Meals/snacks missed	number	1 m						1 s																								
	Exercise	mark days	.5 hr			.5 hr	.5 hr	.5 hr	.5 hr																								
	Relaxation/breaks	mark days		.5 hr	.5 hr	1 hr	1 hr	1 hr																									
	Menstrual cycle	mark days				X	X	X	X																								
Stress	High	mark days	X	X		X	X																										
	Average	mark days			X			X	X																								
	Low	mark days																															
Mood (s)	Very elated or agitated	mark days																															
	Elated or agitated	mark days	X	X																													
	Within normal range	mark days			X				X	X																							
	Depressed	mark days				X	X																										
	Very depressed	mark days																															
Side Effects																																	
	mark days																																
	mark days																																
	mark days																																
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DIRECTIONS

Forms like this can help you and your doctor

- confirm your diagnosis,
- monitor your reactions to a new medication,
- determine what combination of medicines work best for you, and
- review life-style factors that might affect your illness.

- 1 On the first day of each month, record the month and year, and your weight at the top of the form. (If you forget a day—or even an entire month—just start again as soon as you can.)
- 2 List all prescribed medications, vitamins, minerals, and over-the-counter medications you take that month in the Prescription & OTC Meds column at the far left.
- 3 Record the dose for each medication in milligrams (mg), based on one capsule, tablet, etc., in the Dose column. (Check each bottle or box.)
- 4 For each day, record the number of doses you took. (If you miss a day or forget to record a dose, start again as soon as you can.)
- 5 If you consume alcohol, nicotine, or illicit drugs (marijuana, cocaine, etc.), record this information under the appropriate day(s). (This information is important for your treatment and in most cases is kept confidential.)
- 6 For each day, record the total amount in hours or minutes that you slept, exercised, and relaxed or took breaks (other than snack times).
- 7 Record the number of meals and snacks you missed—based on your targeted or usual number of meals and snacks per day. (You can code missed meals and missed snacks differently, as shown by the “m” for meal and “s” for snack on this form.)
- 8 If you’re a menstruating woman, mark the days of your periods with Xs.
- 9 Rate your stress and mood levels each day and mark them with Xs.
10. List side effects at the bottom left and mark the day(s) they occurred.

Keep your completed forms for future reference!

Month Year

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