## Side Effects Journal

<table>
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<th>Date:</th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
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Medication I have taken today.  
[Including: over-the-counter, prescription, herbal, and/or vitamins]  
(Please specify)  

Feelings (mood) [0 -7]  
(where 0 is very sad and 7 is cheerful)  
Anxiety [0 - 7]  
Irritability [0 - 7]  
Angry feelings [0 - 7]  
Poor concentration [0 - 7]  
Thoughts:  
Self-harm: [SH]  
Harming others: [H]  
Suicidal ideas: [Su]  
Activity Levels [0 - 7]  
(where 7 is pre-treatment level)  

Food:  
Breakfast: [B]  
Lunch: [L]  
Supper/Dinner: [SD]  
Snacks: [SK(s)]  
Drinks:  
Water = W  
Other: (Please specify)  

No nausea = 0  
Mild nausea = 1  
Moderate nausea = 2  
Severe nausea = 3  
No vomiting = 0  
1 - 2 times = 1 or 2  
More than 2  
(Please specify the exact number of times)  

Constipation: [C]  
Diarrhea: [D]  
Dry mouth: [DM]  
Fatigue: [Fa]  
Headache: [H]  
Chest pain: [CP]  
Abdominal pain: [AP]  
Breathlessness: [Br]  
Visuial disturbance: [V]  
Dizziness: [Diz]  
Sleep disturbance: [S]  
Other: (Please specify)
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<th>Wednesday</th>
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<th>Friday</th>
<th>Saturday</th>
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