

Symptom Tracker

Symptom Severity: No symptom = 0 Mild = 1 Moderate = 2 Severe = 3

Symptom	Day																																
	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		
a.m.																																	
p.m.																																	
a.m.																																	
p.m.																																	
a.m.																																	
p.m.																																	
Took medication as prescribed	Yes																																
	No																																
Was active today	Yes																																
	No																																
Used drugs or alcohol	Yes																																
	No																																
Hours I slept last night <i>(please write down any problems you have with your sleep)</i>																																	

Comments

Week 1 Weight: _____ **Week 2** Weight: _____ **Week 3** Weight: _____ **Week 4** Weight: _____

BMI: _____ Blood Pressure: _____ Blood Pressure: _____ Blood Pressure: _____

Waist Circumference: _____

Blood Pressure: _____

Identify top three or four symptoms that you will monitor daily until your next meeting with your clinician. Please take a baseline weight, blood pressure, waist circumference, and BMI at the beginning of the month and then monitor weight bi-weekly. Please bring this sheet back with you for your first follow-up meeting so you can talk about it with your treatment team members.

Possible symptoms for daily monitoring by client:

These are only suggestions. There may be other symptoms that you want to monitor.

- | | |
|--|--|
| <ul style="list-style-type: none">• I hear voices or noises and I don't know where they come from.• I think people are watching me or following me. | <ul style="list-style-type: none">• I see things no one else seems to see.• Things sound or smell wrong.• I feel afraid. |
| <ul style="list-style-type: none">• I don't want to do anything.• My mood is extremely happy or elevated.• I think about hurting myself.• I get easily irritated or annoyed.• I feel tired all the time.• I don't need to sleep.• My sex drive is very low, lower than normal. | <ul style="list-style-type: none">• I feel hopeless.• I feel nervous or anxious.• I feel sad or unhappy.• My thoughts move so fast I cannot keep up with them.• People tell me I talk too fast or too much.• My sex drive is very high, higher than normal. |
| <ul style="list-style-type: none">• I can't understand what people are saying to me.• I can't keep my mind on anything.• I don't know how to plan for things. | <ul style="list-style-type: none">• I have trouble remembering things.• I have trouble learning things. |
| <ul style="list-style-type: none">• I can't sleep.• I don't enjoy anything.• I don't brush my teeth. | <ul style="list-style-type: none">• I don't shower.• I don't have anything to say to people. |

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	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
<i>I think people are spying on me</i>	a.m.	1	1	2	1	1	1	1	1	1	1	1	0	1	1																
	p.m.	2	3	3	3	2	2	2	2	1	1	1	1	1	1																
<i>I am afraid</i>	a.m.	2	2	2	3	2	2	1	1	1	1	0	0	0																	
	p.m.	2	2	2	3	2	2	2	2	2	2	1	1	1	0																
	a.m.																														
	p.m.																														
Took medication as prescribed	Yes	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓																
	No		✓	✓																											
Was active today	Yes				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓																
	No	✓	✓	✓						✓																					
Used drugs or alcohol	Yes		✓	✓	✓		✓	✓			✓																				
	No	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓																
Hours I slept last night (please write down any problems you have with your sleep)		5	3	4	7	7	6½	6	7	7	7	8	8	7	6	7															
Comments	<i>I don't sleep well if I think someone is watching me</i>																														

Week 1 Weight: 193 **Week 2** Weight: _____ **Week 3** Weight: _____ **Week 4** Weight: _____
 BMI: 37 Blood Pressure: _____ Blood Pressure: _____ Blood Pressure: _____
 Waist Circumference: 36
 Blood Pressure: 143/90