Child/Adolescent Symptom Monitoring Form

Date: ________________________ Child's Name: ____

Parent Completing Form: ____

Therapist: ____

Symptoms	Day by Day (Following Therapy)						
	Day 1	*Day 2*	*Day 3*	*Day 4*	*Day 5*	*Day 6*	*Day 7*
Stomach aches							
Diarrhea/Constipation							
Sleep Disturbance							
Behavioral Problems							
Tantrums/Acting Out							
Crying							
Avoidance Behaviors							
Agitation							
Urination/Bowel Problems							
Refusal Behavior							
Anxiety							
Change in eating habits							
Headaches							

Note: 1 = minimal, 2 = moderate, 3 = severe

Other symptoms possibly related to treatment:

Symptoms	Day by Day						
	Day 1	*Day 2*	*Day 3*	*Day 4*	*Day 5*	*Day 6*	*Day 7*

Note: 1 = minimal, 2 = moderate, 3 = severe

Additional Comments/Concerns:

____

____

____

____

____

____

____

____

Please complete this form and bring it to your child's next session. Thank you!