HEALTHY CHOICES WORKSHEET

Name: Date:

My medication treatment goal is:

_____

_____

The name of my medication is:

_____

_____

It also may help with:

- Sadness
- Mood swings
- Worries
- Paying attention
- Hyperactivity
- Nightmares
- Hearing/seeing things others don't.
- Being able to sleep.
- Becoming easily angry.
- Thinking things through before I act or react.

My medication might cause side effects, which could include (circled items):

- Harmful thoughts
- Increased worries
- Feeling tired, sleepy
- Muscle stiffness
- Headaches
- Upset stomach
- Weight gain
- Weight loss
- Trouble sleeping
- Increased appetite
- Decreased appetite

Some of my strengths are:

_____

_____

In addition to taking medicine, some things I can do to feel/ do better are:

_____

_____

People I can trust to call for help or questions are:

1. _____ Contact:_____
2. _____ Contact:_____