Minds Matter
Ohio Psychotropic Medication Quality Improvement Collaborative

SCREENING AND MONITORING TOOL

Client Name	Date of Birth / /	Soc. Sec.# - -
Gender ☐ Male ☐ Female	Language	Medicaid ID #
Parent/Guardian Name		Relationship
Email		Phone 2 - -
Address	City	State
Prescriber	Phone	

Baseline Monitoring								
		Follow-Up						
Initial Assessment	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Blood Pressure								
Pulse								
Height								
Weight								
BMI								
Lipids								
Glucose								

Physical Illness (Blank = none, 1= mild, 2= moderate, 3= severe)							
	Follow-Up						
Initial Assessment Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Upper respiratory infection							
Lower respiratory infection							
Bacterial infection							
Swollen glands							
Urinary tract infection							
Feeling flushed or warm							
(Other) fever							
Feeling cold or chills							
Gastrointestinal virus							
Allergies/asthma							
Other							

Symptom Assessment (Blank = none, 1= mild, 2= moderate, 3= severe)								
		Follow-Up						
Initial Assessment	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Safety	Bullying/bullied							
	Suicide							
	Self-injury							
	Property destruction							
	Aggression							
	Verbally threatening							
	Other:							

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Symptom Assessment (Blank = none, 1= mild, 2= moderate, 3= severe)								
			Follow-Up					
Initial Assessment		Date:	Date:	Date:	Date:	Date:	Date:	Date:
Mood	Sadness							
	Irritability							
	Manic							
	Anhedonia (lack pleasure)							
	Dysregulation							
	Other:							
Anxiety	Worry/fear							
	Avoidance							
	Obsessive thoughts							
	Compulsive rituals							
	Panic attacks							
	Somatic complaints							
	Traumatic stress/ flashbacks/hyperarousal							
	Other:							
Disruptive behavior	Inattentive							
	Hyperactive							
	Impulsive							
	Oppositional/defiant							
	Conduct/antisocial							
	Other							
Develop./ cognitive	Social/comm. impairment							
	Rigid/inflexible thinking							
	Stereotypic interests/behaviors							
	Processing/memory deficits							
	Difficulty with transitions							
	Attachment problems							
	Psychotic symptoms							
	Other:							
Neurologic/ somatic	Sleep/eating/body image							
	Tics							
	Other:							
Substance use	Alcohol							
	Marijuana							
	Prescription/OTC drugs/herbal							
	Tobacco							
	Inhalants							
	Methamphetamine							
	Crack/cocaine							
	Heroine							
	Hallucinogens/IV/other:							
Risk behaviors/ identity concerns	Legal problems							
	Truancy							
	Runaway							
	Gender concerns							
	Sex (early /unprotected)							
	Sexual orientation							
	Other:							

Screening Tools					
Name of Tool	**Date/Score**	**Date/Score**	**Date/Score**	**Date/Score**	**Date/Score**

Initial Medications			
Date Started	**Medication**	**Dosage**	**Diagnosis/Behavior**
/ /			
/ /			
/ /			
/ /			

Psychosocial Therapies			
Therapy Type 1		**Initiation Date**	
Observations/Progress/Recommendations			**Date**
Therapy Type 2		**Initiation Date**	
Observations/Progress/Recommendations			**Date**
Therapy Type 3		**Initiation Date**	
Observations/Progress/Recommendations			**Date**

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Side Effect Profile (Blank = none, 1= mild, 2= moderate, 3= severe)								
Screening and Follow-Up			**Updates**					
		Date:	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Vision	Blurriness							
	Double vision							
	Irritation or redness							
	Eye Pain							
	Watering							
	Eye twitching							
	Dryness							
	Light sensitivity							
Hearing	Ear ache							
	Ear infection							
	Poor hearing							
	Ringing in ears							
Head	Headache							
	Facial pain							
	Facial muscle weakness							
Nose	Nose bleeds							
	Nose dryness							
	Sinus congestion							
	Change in smell							
Throat	Sore throat							
	Hoarse voice/laryngitis							
	Difficulty swallowing							
Mouth/Lips	Mouth ulcers/sores							
	Dry mouth							
	Gum/dental problems							
	Too much saliva/drooling							
	Sore/swollen tongue							
	Bad taste in mouth							
Chest	Pain							
	Tightness							
	Shortness of breath							
	Wheezing							
	Coughing							
Breast	Swelling							
	Pain							
	Discharge							
Heart	Rapid heartbeat							
	Irregular heartbeat							
	Slow heartbeat							
Stomach	Pain/Discomfort							
	Heartburn/Reflux							
	Nausea							
	Vomiting							
Appetite	Increased appetite							
	Decreased appetite							
	Taste abnormality							
	Weight gain/loss (___lbs.)							
	Increased thirst							

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Side Effect Profile (Blank = none, 1= mild, 2= moderate, 3= severe)								
Screening and Follow-Up			**Updates**					
		Date:	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Urination	Painful							
	Difficulty							
	Increase urination							
	Bedtime wetting							
	Daytime wetting							
	Change in color/smell							
Bowels	Diarrhea							
	Stool discoloration							
	Constipation							
	Hemorrhoids							
	Blood in stool							
	Bloated/gassy							
Menstrual	Irregular periods							
	Mid-cycle pain							
	Cramping							
	Premenstrual tension/mood							
	Increased bleeding							
	Breakthrough bleeding							
Genital	Genital discomfort/swelling							
	Decreased urges/interests sex							
	Discharge							
	Sexual dysfunction							
	Increased urges/Interest in sex							
Muscles, Bones, Joints	Pain							
	Numbness							
	Swelling/fluid buildup							
	Tingling							
	Cramps/contractions							
	Restless legs							
Movement	Clumsiness/poor coordination							
	Restlessness							
	Tics (twitches, blinking, making sounds)							
	Tremor, trembling or shaking							
	Rigidity, aches, cramps							
Sleep	Difficulty falling asleep							
	Sleeping too much							
	Interrupted sleep							
	Awaken not feeling rested							
	Early morning awakening							
	Drowsiness							
	Nightmares							
Energy	Tiredness/fatigue							
	Sedation/drugged feeling							
	Overly excited/energetic							
	Withdrawn							
	Staring							
	Too keyed up/can't settle down							

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Side Effect Profile (Blank = none, 1= mild, 2= moderate, 3= severe)								
Screening and Follow-Up			**Updates**					
		Date:	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Skin/Hair	Rashes/irritation							
	Flaking scalp							
	Change in body odor							
	Pimples/acne							
	Sensitive to Sun							
	Hair Problems (loss, brittle)							
	Hives							
	Blisters							
	Oily skin/hair							
	Dry Skin							
	Excessive Sweating							
	Easy Bruising							
Strange Experiences /Thoughts	See things not there							
	Hear things not there							
	Smell/taste things not there							
	Strange physical feelings							
	Strange thoughts or ideas							
Thinking	Memory problems							
	Speech difficulty/changes							
	Concentration difficulty							
	Dizziness/faintness							
	Confusion							
	Slowed thinking							
	Loss of consciousness							
Mood Changes	Depressed							
	Irritable							
	Anxious/nervous							
	"Manicky"							
	Loss of Interest/motivation							
Accident/ Injury	Accidental injury (describe)							
	Attempted suicide							
	Self-harmful behavior (cutting on self, banging head, etc.)							
Other								

Medication Adjustments			
Date	**Medication Name**	**Adjustment Made**	**Reason for Change**
/ /			
/ /			
/ /			
/ /			
/ /			
/ /			

Abnormal Involuntary Movement Scale (AIMS) – Every 6 Months

Instructions: Complete examination procedure (**next page**) before making ratings.

Code
0=None 1=Minimal, may be extreme normal 2=Mild 3=Moderate 4-Severe

Movement Ratings: Rate highest severity observed. Rate movements that occur upon activation one less than those observed spontaneously. Circle movement as well as code number that applies.

Screening and Follow-Up			Updates			
		Date:	Date:	Date:	Date:	Date:
Facial and oral movement	1. **Muscles of Facial Expression** e.g. movements of forehead, eyebrows, periorbital area, cheeks, including frowning, blinking, smiling, grimacing	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4
	2. **Lips and Perioral Area** e.g., puckering, pouting, smacking	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4
	3. **Jaw** e.g. biting, clenching, chewing, mouth opening, lateral movement	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4
	4. **Tongue** Rate only increases in movement both in and out of mouth. NOT inability to sustain movement. Darting in and out of mouth.	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4
Extremity movement	5. **Upper (arms, wrists, hands, fingers)** Include choreic movements (i.e., rapid, objectively purposeless, irregular, spontaneous) athetoid movements (i.e., slow, irregular, complex, serpentine). DO NOT INCLUDE TREMOR (i.e., repetitive, regular, rhythmic)	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4
	6. **Lower (legs, knees, ankles, toes)** e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot.	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4
Trunk movement	7. **Neck, shoulders, hips** e.g., rocking, twisting, squirming, pelvic gyrations	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4
Global judgments	8. **Severity of abnormal movements overall**	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4
	9. **Incapacitation due to abnormal movements**	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4
	10. **Incapacitation due to abnormal movements** Rate only patient's report. No awareness=0 Aware, no distress=1 Aware, mild distress=2 Aware, moderate distress=3 Aware, severe distress=4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4	☐0 ☐1 ☐2 ☐3 ☐4
Dental status	11. **Current problems with teeth and/or dentures?**	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	12. **Are dentures usually worn?**	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	13. **Edentia?**	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Abnormal Involuntary Movement Scale (AIMS) Examination Procedure

Definition

The Abnormal Involuntary Movement Scale (AIMS) is a rating scale that was designed in the 1970s to measure involuntary movements known as tardive dyskinesia (TD). TD is a disorder that sometimes develops as a side effect of long-term treatment with neuroleptic (antipsychotic) medications.

Purpose

Tardive dyskinesia is a syndrome characterized by abnormal involuntary movements of the patient's face, mouth, trunk, or limbs, which affects 20%–30% of patients who have been treated for months or years with neuroleptic medications. Patients who are older, are heavy smokers, or have diabetes mellitus are at higher risk of developing TD. The AIMS test is used not only to detect tardive dyskinesia but also to follow the severity of a patient's TD over time. It is a valuable tool for clinicians who are monitoring the effects of long-term treatment with neuroleptic medications and also for researchers studying the effects of these drugs. The AIMS test is given every three to six months to monitor the patient for the development of TD. For most patients, TD develops three months after the initiation of neuroleptic therapy; in elderly patients, however, TD can develop after as little as one month.

Abnormal Involuntary Movement Scale (AIMS) Examination Procedure

Results

The total score on the AIMS test is not reported to the patient. A rating of 2 or higher on the AIMS scale, however, is evidence of tardive dyskinesia. If the patient has mild TD in two areas or moderate movements in one area, then he or she should be given a diagnosis of TD. The AIMS test is considered extremely reliable when it is given by experienced raters. If the patient's score on the AIMS test suggests the diagnosis of TD, the clinician must consider whether the patient still needs to be on an antipsychotic medication. This question should be discussed with the patient and his or her family. If the patient requires ongoing treatment with antipsychotic drugs, a lower dosage or alternative medication should be considered.

Procedure

Either before or after completing the examination procedure, observe the patient unobtrusively at rest (e.g., in the waiting room). The chair to be used in this examination should be a hard, firm one without arms. Have the person remove their shoes and socks.

1. Ask the patient whether there is anything in his or her mouth (such as gum or candy) and, if so, to remove it.
2. Ask about the *current* condition of the patient's teeth. Ask if he or she wears dentures. Ask whether teeth or dentures bother the patient *now*.
3. Ask whether the patient notices any movements in his or her mouth, face, hands, or feet. If yes, ask the patient to describe them and to indicate to what extent they *currently* bother the patient or interfere with activities.
4. Have the patient sit in chair with hands on knees, legs slightly apart, and feet flat on floor. (Look at the entire body for movements while the patient is in this position.)
5. Ask the patient to sit with hands hanging unsupported -- if male, between his legs, if female and wearing a dress, hanging over her knees. (Observe hands and other body areas).
6. Ask the patient to open his or her mouth. (Observe the tongue at rest within the mouth.) Do this twice.
7. Ask the patient to protrude his or her tongue. (Observe abnormalities of tongue movement.) Do this twice.
8. Ask the patient to tap his or her thumb with each finger as rapidly as possible for 10 to 15 seconds, first with right hand, then with left hand. (Observe facial and leg movements.)*
9. Flex and extend the patient's left and right arms, one at a time.
10. Ask the patient to stand up. (Observe the patient in profile. Observe all body areas again, hips included.)
11. Ask the patient to extend both arms out in front, palms down. (Observe trunk, legs, and mouth.)*
12. Have the patient walk a few paces, turn, and walk back to the chair. (Observe hands and gait.) Do this twice.*

*Activated movements

Additional Notes	
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