

**THE UKU SIDE EFFECTS RATING SCALE SCALE FOR THE  
REGISTRATION OF UNWANTED EFFECTS OF PSYCHOTROPICS  
MANUAL ENGLISH VERSION, October 1986  
(UKU)**

Patient Information									
Patient		Date	Day	Mth.	Year	Time	Hour	Min	
Personal notes									

Psychic										
Category of side effects	Symptom	Not Ass.	Degree last 3 days (see manual)					Causal realationsship		
		9	0	1	2	3	Imp	Pos	Prb	
1.1	Concentration Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
1.2	Astheniat/Lassitude/Increased Fatigability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
1.3	Sleepiness/Sedation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
1.4	Failing Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
1.5	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
1.6	Tension/Inner Unrest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
1.7	Increased Duration of Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
1.8	Reduced Duration of Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
1.9	Increased Dream Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
1.10	Emotional indifference	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Neurologic										
Category of side effects	Symptom	Not Ass.	Degree last 3 days (see manual)					Causal relationship		
		9	0	1	2	3	Imp	Pos	Prb	
2.1	Dystonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2	Rigidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.3	Hypokinesia/Akinesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.4	Hyperkinesia logic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.5	Tremor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.6	Akathisia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.7	Epileptic Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.8	Paraesthesias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Autonomic										
Category of side effects	Symptom	Not Ass.	Degree last 3 days (see manual)					Causal realationsship		
		9	0	1	2	3	Imp	Pos	Prb	
3.1	Accommodation Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.2	Increased Salivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.3	Reduced Salivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.4	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.5	Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.6	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.7	Micturition Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.8	Polyuria/Polydipsia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.9	Orthostatic Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.10	Palpitations/Tachycardia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.11	Increased Tendency to Sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Other										
Category of side effects	Symptom	Not Ass.	Degree last 3 days (see manual)					Causal relationship		
			9	0	1	2	3	Imp	Pos	Prb
4.1	Rash	<input type="checkbox"/>	<input type="checkbox"/>							
4.1a	- Morbilliform			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.1b	- Petechial			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.1c	- Urticarial			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.1d	- Psoriatic			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.1e	- Cannot be classified			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.2	Pruritus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.3	Photosensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.4	Increased Pigmentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.5	Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.6	Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.7	Menorrhagia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.8	Amenorrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.9	Galactorrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.10	Gynaecomastia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.11	Increased Sexual Desire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.12	Diminished Sexual Desire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.13	Erectile Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.14	Ejaculatory Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.15	Orgastic Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.16	Dry Vagina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Other-continued										
Category of side effects	Symptom	Not Ass.	Degree last 3 days (see manual)					Causal relationship		
			9	0	1	2	3	Imp	Pos	Prb
4.17	Headache	<input type="checkbox"/>	<input type="checkbox"/>							
4.17a	- Tension headache			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.17b	- Migraine			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.17c	- Other forms			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.18	Physical Dependence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.19	Psychic Dependence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Global assessment of the interference by existing side effects with the patient's daily performance:		Assessed by	
		Patient	Doctor
0	No side effects	<input type="checkbox"/>	<input type="checkbox"/>
1	Mild side effects that do not interfere with the patient's performance	<input type="checkbox"/>	<input type="checkbox"/>
2	Side effects that interfere moderately with the patient's performance	<input type="checkbox"/>	<input type="checkbox"/>
3	Side effects that interfere markedly with the patient's performance	<input type="checkbox"/>	<input type="checkbox"/>

Consequence		
0	No action	<input type="checkbox"/>
1	More frequent assessment of the patient, but no reduction of dose, and/or occasional drug treatment of side effects	<input type="checkbox"/>
2	Reduction of dose and/or continuous drug, treatment of side effects	<input type="checkbox"/>
3	Discontinuation of drug or change to another preparation	<input type="checkbox"/>

	Date	Day	Mth.	Year	Time	Hour	Min
<b>Signature:</b>							

## GENERAL REMARKS

Assessment of the individual symptoms is best accomplished by a semistructured interview with the patient during which the scale is gone through point by point (but not necessarily in the order given in the form). The interview should be supplemented by clinical observation and information obtained from the ward staff and case records.

As appears from the manual, most of the symptoms call for a "here and now assessment", but it is often appropriate to assess the patient's condition during the preceding three days. For some symptoms the basis of assessment will be a longer period than 72 hours, as specified in the manual (for instance changes in weight, menstrual disturbances, convulsions, physical and psychic dependence).

Particularly in the case of items belonging to the group of psychic side effects there may be discrepancies between the patient's complaints and clinical signs or findings during the interview. As a general rule the clinical observations should be given precedence.

If for some reason a symptom cannot be assessed, this should be indicated by placing a cross in the proper column (Not Assessed).

It is important that the rating should be independent of the question whether or not the symptom is regarded as being drug-induced. The probability of correlation with the treatment administered should be indicated in a separate column.

Each item is defined by means of a 4-point-scale (0-1-2-3). In general, Degree 0 means "not or doubtfully present". As a general rule Degree 0 refers to the "normal" (the average of healthy people) and not to the usual condition of the patient. Exceptions to this rule are made for some items where it is clinically more meaningful to refer to the usual condition, i.e. the condition before the patient got ill. This applies to sleep (Items 1.7. and 1.8.), dream activity (item 1.9.), weight (Items 4.5. and 4.6.), menstrual disturbances (Items 4.7. and 4.8.), and also to symptoms of sexual disorders (Items 4.11.-4.16.).

In general Degrees 1, 2, and 3 indicate that a symptom is present to a mild, moderate or severe degree, respectively. The examples given for some items as illustrations of the scale points in question are to be regarded as guidelines and not as obligatory components of the operational definition of the items.

The assessment of possible relation to the administered drug must be made on the basis of previous knowledge of the patient and clinical judgement. It is important that this assessment should be made for all symptoms that are rated 1, 2, or 3.

In the last column those drug-induced symptoms are checked which the interviewer believes should be reported to the appropriate authority.

It should be noted that after each main group (psychic, neurologic, autonomic, others) space has been provided for additional side effects to be recorded.

In the global assessment of side effects an independent assessment by both the patient and the interviewer should, if possible, be carried out. The global assessment should be made on the basis of the degree to which the side effects interfere with the patient's daily performance.



At the bottom of the form the interviewer should record what measures have been taken on the basis of the information recorded about side effects, using the following scale: 0 = no action, 1 = more frequent assessment of the patient, but no reduction of dose, and/or occasional drug treatment of side effects, 2 = reduction of dose and/or continuous drug treatment of side effects, 3 = discontinuation of drug or change to another preparation.

## 1. PSYCHIC SIDE EFFECTS

### 1.2 Asthenia/Lassitude/Increased Fatiguability

The patient's experience of lassitude and lack of endurance. The assessment is based upon the patient's reported statements.

<b>0</b> = No or doubtful lassitude.	<input type="checkbox"/>
<b>1</b> = The patient tires more easily than usual; however, this does not mean that the patient needs to rest more than usual during the day.	<input type="checkbox"/>
<b>2</b> = Must rest now and then during the day because of lassitude.	<input type="checkbox"/>
<b>3</b> = Must rest most of the day because of lassitude.	<input type="checkbox"/>

### 1.3. Sleepiness/Sedation

Diminished ability to stay awake during the day. The assessment is based on clinical signs during the interview.

<b>0</b> = No or doubtful sleepiness.	<input type="checkbox"/>
<b>1</b> = Slightly sleepy/drowsy as regards facial expression and speech.	<input type="checkbox"/>
<b>2</b> = More markedly sleepy/drowsy. The patient yawns and tends to fall asleep when there is a pause in the conversation.	<input type="checkbox"/>
<b>3</b> = Difficult to keep the patient awake and to wake the patient, respectively.	<input type="checkbox"/>

**1.4. Failing Memory**

Impaired memory. Assessment should be independent of any concentration difficulties.

<b>0</b> = No or doubtful disturbance of memory.	<input type="checkbox"/>
<b>1</b> = Slight, subjective feeling of reduced memory compared with the patient's usual condition; however, not interfering with functioning.	<input type="checkbox"/>
<b>2</b> = The failing memory hampers the patient and/or slight signs of this are observed during the interview.	<input type="checkbox"/>
<b>3</b> = The patient has shown clear signs of failing memory during the interview.	<input type="checkbox"/>

**1.5. Depression**

Includes both the verbal and the non-verbal expressions of the patient's experience of sadness, depression, melancholy, hopelessness, helplessness, perhaps with suicidal impulses.

<b>0</b> = Neutral or elated mood.	<input type="checkbox"/>
<b>1</b> = The patient's mood is somewhat more depressed and sad than usual; however, the patient still finds life worth living.	<input type="checkbox"/>
<b>2</b> = The patient's mood is clearly depressed, perhaps including non-verbal expressions of hopelessness and/or wishes of dying, but the patient has no direct plans to commit suicide.	<input type="checkbox"/>
<b>3</b> = The patient's verbal and non-verbal expressions of hopelessness and sadness are great and/or it is considered highly likely that he plans to commit suicide.	<input type="checkbox"/>

**1.6. Tension/Inner Unrest**

Inability to relax, nervous restlessness. This item is to be assessed on the basis of the patient's experience and must be distinguished from motor akathisia (Item 2.6.).

<b>0</b> = No or doubtful tension/nervous restlessness.	<input type="checkbox"/>
<b>1</b> = The patient states that he is slightly tense and restless; however, this does not interfere with his functioning.	<input type="checkbox"/>
<b>2</b> = Considerable tension and inner unrest; however, without this being so intense or constant that the patient's daily life is influenced to any marked degree.	<input type="checkbox"/>
<b>3</b> = The patient feels tension or restlessness that is so marked that his daily life is clearly affected.	<input type="checkbox"/>

**1.7. Increased Duration of Sleep**

This should be assessed on the basis of the average of sleep over the three preceding nights. The assessment is to be made in relation to the patient's usual pre-illness state.

<b>0</b> = No or doubtful increase of the duration of sleep.	<input type="checkbox"/>
<b>1</b> = Sleeps up to 2 hours longer than usual.	<input type="checkbox"/>
<b>2</b> = Sleeps 2 or 3 hours longer than usual.	<input type="checkbox"/>
<b>3</b> = Sleeps more than 3 hours longer than usual.	<input type="checkbox"/>

**1.8. Reduced Duration of Sleep**

Should be assessed on the basis of the average of sleep over the three preceding nights. The assessment is to be made in relation to the patient's usual pre-illness state.

<b>0</b> = No or doubtful reduction of the duration of sleep.	<input type="checkbox"/>
<b>1</b> = Sleeps up to 2 hours less than usual.	<input type="checkbox"/>
<b>2</b> = Sleeps 2 or 3 hours less than usual.	<input type="checkbox"/>
<b>3</b> = Sleeps more than 3 hours less than usual.	<input type="checkbox"/>

**1.9. Increased Dream Activity**

Should be assessed independently of dream content and based on the average of sleep over the three preceding nights in relation to the usual pre-illness dream activity.

<b>0</b> = No or doubtful change in the dream activity.	<input type="checkbox"/>
<b>1</b> = Slightly increased dream activity, which does not disturb the night's sleep, however.	<input type="checkbox"/>
<b>2</b> = More pronounced increase of dream activity.	<input type="checkbox"/>
<b>3</b> = Very pronounced increase of dream activity.	<input type="checkbox"/>

**1.10. Emotional Indifference**

A diminution of the patient's empathy, leading to apathy.

<b>0</b> = No or doubtful emotional indifference.	<input type="checkbox"/>
<b>1</b> = Slight subduing of the patient's empathy.	<input type="checkbox"/>
<b>2</b> = Obvious emotional indifference.	<input type="checkbox"/>
<b>3</b> = Pronounced indifference so that the patient behaves apathetically in relation to his surroundings.	<input type="checkbox"/>

**2. NEUROLOGICAL SIDE EFFECTS****2.1. Dystonia**

Acute forms of dystonia in the form of tonic muscular contractions localized to one or several muscle groups, particularly in the mouth, tongue, and/or neck. The assessment is to be made on the basis of the last three days preceding the examination.

<b>0</b> = No or doubtful dystonia.	<input type="checkbox"/>
<b>1</b> = Very slight or short spasms, for instance in the musculature of the jaws or the neck.	<input type="checkbox"/>
<b>2</b> = More pronounced contractions of a longer duration and/or of a wider localization.	<input type="checkbox"/>
<b>3</b> = Marked forms of for instance oculogyric crises or opisthotonos.	<input type="checkbox"/>

**2.2. Rigidity**

Increased muscle tone of a uniform and general nature, observed on the basis of a uniform, steady resistance to passive movements of the limbs. Special importance is attached to the muscles around the elbow joints and shoulders.

<b>0</b> = No or doubtful rigidity.	<input type="checkbox"/>
<b>1</b> = Slight rigidity in neck, shoulder, and extremities. It must be possible to observe the rigidity on the basis of resistance to passive movements of the elbow joints.	<input type="checkbox"/>
<b>2</b> = Medium rigidity assessed on the basis of resistance to passive movements of for instance the elbow joints.	<input type="checkbox"/>
<b>3</b> = Very marked rigidity.	<input type="checkbox"/>

**2.3. Hypokinesia/Akinesia**

Slow movements (bradykinesia), reduced facial expression, reduced arm swinging, reduced length of stride, perhaps leading to cessation of movement (akinesia).

<b>0</b> = No or doubtful hypokinesia.	<input type="checkbox"/>
<b>1</b> = Slightly reduced movement, for instance slightly reduced swinging of an arm when walking or slightly reduced facial expressions.	<input type="checkbox"/>
<b>2</b> = More clear reduction of mobility, for instance slow walking.	<input type="checkbox"/>
<b>3</b> = Very marked reduction of mobility, bordering on and including akinesia, e.g. Parkinsonian mask and/or very short length of stride.	<input type="checkbox"/>

**2.4. Hyperkinesia**

Involuntary movements, most frequently affecting the oro-facial region in the form of the so-called bucco-lingumasticatory syndrome. However, it is often also seen in the extremities, especially the fingers, more rarely in the musculature of the body and the respiratory system. Both initial and tardive hyperkinesias are included.

<b>0</b> = No or doubtful hyperkinesia.	<input type="checkbox"/>
<b>1</b> = Slight hyperkinesia, only present intermittently.	<input type="checkbox"/>
<b>2</b> = Moderate hyperkinesia, present most of the time.	<input type="checkbox"/>
<b>3</b> = Severe hyperkinesia, present most of the time, with for instance marked tongue protrusion, opening of the mouth, facial hyperkinesia, with or without involvement of the extremities.	<input type="checkbox"/>

**2.5. Tremor**

This item comprises all forms of tremor.

<b>0</b> = No or doubtful tremor.	<input type="checkbox"/>
<b>1</b> = Very slight tremor that does not hamper the patient.	<input type="checkbox"/>
<b>2</b> = Clear tremor hampering the patient, the amplitude of finger tremor being less than 3 cm.	<input type="checkbox"/>
<b>3</b> = Clear tremor with an amplitude of more than 3 cm and which cannot be controlled by the patient.	<input type="checkbox"/>

**2.6 Akathisia**

A subjective feeling and objective signs of muscle unrest, particularly in the lower extremities, so that it may be difficult for the patient to remain seated. Assessment of this item is based on clinical signs observed during the interview, as well as on the patient's report.

<b>0</b> = No or doubtful akathisia.	<input type="checkbox"/>
<b>1</b> = Slight akathisia; however, the patient can keep still without effort.	<input type="checkbox"/>
<b>2</b> = Moderate akathisia; however, the patient can, with an effort, remain sitting during the interview.	<input type="checkbox"/>
<b>3</b> = When the patient has to rise to his feet several times during the interview because of akathisia.	<input type="checkbox"/>

**2.7. Epileptic Seizures**

Only generalised tonic-clonic seizures are to be recorded here.

<b>0</b> = No seizures within the last 6 months.	<input type="checkbox"/>
<b>1</b> = One single seizure within the last 6 months.	<input type="checkbox"/>
<b>2</b> = 2 or 3 seizures within the last 6 months.	<input type="checkbox"/>
<b>3</b> = More than 3 seizures within the last 6 months.	<input type="checkbox"/>

**2.8. Paraesthesias**

Pricking, creeping, or burning; sensations in the skin.

<b>0</b> = No or doubtful paraesthesias.	<input type="checkbox"/>
<b>1</b> = Mild paraesthesias, scarcely bothering the patient.	<input type="checkbox"/>
<b>2</b> = Moderate paraesthesias, clearly bothering the patient.	<input type="checkbox"/>
<b>3</b> = Severe paraesthesias, markedly bothering the patient.	<input type="checkbox"/>

**3. AUTONOMIC SIDE EFFECTS****3.1. Accommodation Disturbances**

Difficulty in seeing clearly or distinctly at close quarters (with or without glasses), whereas the patient sees clearly at a long distance. If the patient uses bifocal glasses, the condition must be assessed on the basis of the use Of the distance glasses.

<b>0</b> = No difficulty in reading an ordinary newspaper text.	<input type="checkbox"/>
<b>1</b> = Newspaper text can be read, but the patient's eyes tire rapidly and/or he must hold the paper further away.	<input type="checkbox"/>
<b>2</b> = The patient cannot read an ordinary newspaper text, but still manages to read texts printed in larger types.	<input type="checkbox"/>
<b>3</b> = The patient can read large type, such as a headline, only with aid, such as a magnifying glass.	<input type="checkbox"/>



**3.2. Increased Salivation**

Increased, non-stimulated salivation.

<b>0</b> = No or doubtful increase of salivation.	<input type="checkbox"/>
<b>1</b> = Salivation clearly increased, but not bothersome.	<input type="checkbox"/>
<b>2</b> = Disturbing increase of salivation; need for spitting or frequent swallowing of saliva; only exceptional dribbling.	<input type="checkbox"/>
<b>3</b> = Frequent or constant dribbling, perhaps concomitant speech disturbances.	<input type="checkbox"/>

**3.3. Reduced Salivation (Dryness of Mouth)**

Dryness of mouth because of diminished salivation. May result in increased consumption of liquids, but must be distinguished from thirst.

<b>0</b> = No or doubtful dryness of mouth.	<input type="checkbox"/>
<b>1</b> = Slight dryness of mouth, not disturbing to the patient.	<input type="checkbox"/>
<b>2</b> = Moderate and slightly disturbing dryness of mouth.	<input type="checkbox"/>
<b>3</b> = Marked dryness of mouth which clearly disturbs the patient's daily life.	<input type="checkbox"/>

**3.4. Nausea/Vomiting**

To be recorded on the basis of the last 3 days.

<b>0</b> = No or doubtful nausea.	<input type="checkbox"/>
<b>1</b> = Slight nausea.	<input type="checkbox"/>
<b>2</b> = Disturbing nausea, but without vomiting.	<input type="checkbox"/>
<b>3</b> = Nausea with vomiting.	<input type="checkbox"/>

**3.5 Diarrhoea**

Increased frequency of defaecation and/or thinner consistency of faeces.

**0** = No or doubtful diarrhoea.☐**1** = Clearly present, but does not disturb work or other performance.☐**2** = Disturbing, with need for several daily, inconvenient stools.☐**3** = Marked, imperative need for defaecation, threatening or actual incontinence, results in frequent interruptions of work.☐**3.6 Constipation**

Reduced frequency of defaecation and/or thicker consistency of faeces.

**0** = No or doubtful constipation.☐**1** = Slight constipation, but bearable.☐**2** = More marked constipation which hampers the patient.☐**3** = Very pronounced constipation.☐**3.7. Micturition Disturbances**

Feeling of difficulty in starting and of resistance to micturition, weaker stream and/or increased time of micturition. Should be assessed on the basis of the last 3 days.

**0** = No or doubtful micturition disturbance.☐**1** = Clearly present, but bearable.☐**2** = Poor stream, considerably increased time of micturition, feeling of incomplete emptying of bladder.☐**3** = Retention of urine with high volume residual urine and/or threatened or actual acute retention.☐

**3.8. Polyuria/Polydipsia**

Increased urine production resulting in increased frequency of micturition and discharge of an abundant quantity of urine at each micturition; secondarily increased consumption of fluid.

<b>0</b> = No or doubtful.	<input type="checkbox"/>
<b>1</b> = Clearly present, but not hampering. Nocturia: At most once a night (in young people).	<input type="checkbox"/>
<b>2</b> = Moderately hampering because of frequent thirst, nocturia two or three times a night, or micturition more frequent than every two hours.	<input type="checkbox"/>
<b>3</b> = Very hampering, almost constant thirst, nocturia at least four times a night, or micturition at least every hour.	<input type="checkbox"/>

**3.9. Orthostatic Dizziness**

Feeling of weakness, everything going black, buzzing in the ears, increasing tendency to faint when changing from supine or sitting position to upright position.

<b>0</b> = No or doubtful.	<input type="checkbox"/>
<b>1</b> = Clearly present, but requires no special countermeasures.	<input type="checkbox"/>
<b>2</b> = Hampering, but can be neutralized by slow and/or stagewise change to upright position.	<input type="checkbox"/>
<b>3</b> = Threatening fainting or real episodes of fainting, despite careful change of position, with a tendency to this type of dizziness as long as the patient is in an upright position.	<input type="checkbox"/>

**3.10. Palpitations/Tachycardia**

Palpitation, feeling of rapid, strong and/or irregular heartbeats.

<b>0</b> = No or doubtful.	<input type="checkbox"/>
<b>1</b> = Clearly present, but not hampering, only short occasional attacks or more constant, but not marked palpitation.	<input type="checkbox"/>
<b>2</b> = Hampering frequent or constant palpitation that worries the patient or disturbs his night's sleep; however, without concomitant symptoms.	<input type="checkbox"/>
<b>3</b> = Suspicion of real tachycardia, for instance because of concomitant feeling of weakness and need to lie down, dyspnoea, tendency to fainting, or precordial pain.	<input type="checkbox"/>

**3.11. Increased Tendency to Sweating**

Localized to the whole body, not only palms and soles of the foot.

<b>0</b> = No or doubtful.	<input type="checkbox"/>
<b>1</b> = Clearly present, but mild, for example a profuse outburst of sweat only after considerable effort.	<input type="checkbox"/>
<b>2</b> = Hampering, requires frequent change of clothes, profuse sweating after moderate activity, for instance walking up stairs.	<input type="checkbox"/>
<b>3</b> = Profuse outbursts of sweat after slight activity or when resting, the patient is constantly wet, must change clothes several times a day and must also change night clothes and/or bedclothes.	<input type="checkbox"/>

**4. OTHER SIDE EFFECTS****4.1. Rash**

On the scoring sheet the type of rash is classified as a) morbilliform, b) petechial, c) urticarial, d) psoriatic, and e) cannot be classified. The following grading is used:

<b>0</b> = No or doubtful rash.	<input type="checkbox"/>
<b>1</b> = Localized to less than 5 per cent of the skin surface, for instance to the palms.	<input type="checkbox"/>
<b>2</b> = Scattered all over the skin, but covers less than 1/3 of the skin surface.	<input type="checkbox"/>
<b>3</b> = Universal, i.e. covers more than 1/3 of the skin surface.	<input type="checkbox"/>

**4.2. Pruritus**

<b>0</b> = No or doubtful.	<input type="checkbox"/>
<b>1</b> = Slight pruritus.	<input type="checkbox"/>
<b>2</b> = Pronounced pruritus, so that the patient is being hampered. There may be scratch marks.	<input type="checkbox"/>
<b>3</b> = Severe pruritus that markedly hampers the patient. There are distinct skin changes because of scratching.	<input type="checkbox"/>

**4.3. Photosensitivity**

Increased sensitivity to sunlight

<b>0</b> = No or doubtful.	<input type="checkbox"/>
<b>1</b> = Slight, but not hampering.	<input type="checkbox"/>
<b>2</b> = More pronounced and hampering to the patient.	<input type="checkbox"/>
<b>3</b> = So pronounced that drug withdrawal is clearly necessary.	<input type="checkbox"/>

**4.4. Increased Pigmentation**

Increased skin pigmentation of brown or other colour, often localized to parts of the skin exposed to light.

<b>0</b> = No or doubtful increase of pigmentation.	<input type="checkbox"/>
<b>1</b> = Slightly increased pigmentation.	<input type="checkbox"/>
<b>2</b> = Such marked pigmentation, generally or localized, that it worries the patient but is not conspicuous to others.	<input type="checkbox"/>
<b>3</b> = So pronounced that the pigmentation can easily be observed by other people.	<input type="checkbox"/>

**4.5. Weight Gain**

The rating is to be made on the basis of the preceding month.

<b>0</b> = No or doubtful weight gain during the preceding month.	<input type="checkbox"/>
<b>1</b> = Weight gain amounting to 1-2 kg during the preceding month.	<input type="checkbox"/>
<b>2</b> = Weight gain amounting to 3-4 kg during the preceding month.	<input type="checkbox"/>
<b>3</b> = Weight gain amounting to more than 4 kg during the preceding month.	<input type="checkbox"/>

**4.6. Weight Loss**

<b>0</b> = No or doubtful weight loss.	<input type="checkbox"/>
<b>1</b> = Weight loss amounting to 1-2 kg during the preceding month.	<input type="checkbox"/>
<b>2</b> = Weight loss amounting to 3-4 kg during the preceding month.	<input type="checkbox"/>
<b>3</b> = Weight loss amounting to more than 4 kg during the preceding month.	<input type="checkbox"/>

**4.7. Menorrhagia**

Hypermenorrhoea, polymenorrhoea, or metrorrhagia during the last 3 months.

<b>0</b> = No or doubtful increase in frequency or intensity of menstrual flow.	<input type="checkbox"/>
<b>1</b> = Hypermenorrhoea, i.e. the menstrual flow is more intense than usual, the intervals being normal.	<input type="checkbox"/>
<b>2</b> = Polymenorrhoea, i.e. the menstrual flow occurs more frequently and is more intense than normal.	<input type="checkbox"/>
<b>3</b> = Metrorrhagia, i.e. irregular intervals and intensity, the blood loss being more frequent and intense compared with the usual pattern.	<input type="checkbox"/>

**4.8. Amenorrhoea**

Hypomenorrhoea, oligomenorrhoea, or amenorrhoea during the last 3 months.

<b>0</b> = No or doubtful reduction in frequency or intensity of menstrual flow.	<input type="checkbox"/>
<b>1</b> = Hypomenorrhoea, i.e. uterine bleeding of less than the normal amount, but occurring at normal intervals.	<input type="checkbox"/>
<b>2</b> = Oligomenorrhoea, i.e. prolonged intervals compared with the usual condition; the intensity may also be lower than usual.	<input type="checkbox"/>
<b>3</b> = Amenorrhoea, i.e. menstruation has been absent for or more than 3 months.	<input type="checkbox"/>

**4.9. Galactorrhoea**

Increased secretion of milk outside periods of breast feeding.

<b>0</b> = No galactorrhoea.	<input type="checkbox"/>
<b>1</b> = Galactorrhoea present, but to a very slight degree.	<input type="checkbox"/>
<b>2</b> = Galactorrhoea is present to a moderate degree and is felt to be somewhat disturbing.	<input type="checkbox"/>
<b>3</b> = Galactorrhoea is very pronounced and clearly disturbing.	<input type="checkbox"/>

**4.10. Gynaecomastia**

Excessive development of the male mammary glands.

**0** = No gynaecomastia.☐**1** = Gynaecomastia present to a very slight degree compared with the usual state.☐**2** = Gynaecomastia clearly present; however, only hampering when the patient is undressed.☐**3** = Gynaecomastia present to such a severe degree that it affects the patient cosmetically, as it can be observed even if he is dressed.☐**4.11. Increased Sexual Desire**

Increased desire for sexual activity.

**0** = No or doubtful.☐**1** = Slight increase, which is, however, still felt as natural by the partner.☐**2** = Clear increase that has given rise to comments and discussions with the partner.☐**3** = When the usual desire has increased to such a severe extent that the patient's life with his partner is considerably disturbed.☐**4.12. Diminished Sexual Desire**

Reduced desire for sexual activity.

**0** = No or doubtful.☐**1** = The desire for sexual activity is slightly diminished, but without hampering the patient.☐**2** = A distinct reduction of the patient's desire for and interest in sexual activities so that it becomes a problem for the patient.☐**3** = Desire and interest have diminished to such an extent that sexual intercourse occurs extremely seldom or has stopped.☐



**4.13. Erectile Dysfunction**

Difficulty in attaining or maintaining an erection.

**0** = No or doubtful.

☐

**1** = Slightly diminished ability to attain or maintain an erection.

☐

**2** = A distinct change in the patient's ability to attain or maintain an erection.

☐

**3** = The patient only rarely (or never) can attain or maintain an erection.

☐
**4.14. Ejaculatory Dysfunction**

Dysfunction of the patient's ability to control ejaculation. Includes a) premature or b) delayed ejaculation. On the scoring sheet it should be indicated whether a) or b) is present.

**0** = No or doubtful.

☐

**1** = It is somewhat more difficult than usual for the patient to control ejaculation, but it does not trouble him.

☐

**2** = A distinct change in the patient's ability to control ejaculation, so that it becomes a problem for him.

☐

**3** = The patient's ability to control ejaculation is influenced to such an extent that it has become a dominating problem in his sexual intercourse and thus to a great extent influences his experience of orgasm.

☐
**4.15. Orgastic Dysfunction**

Difficulty in obtaining and experiencing satisfactory orgasm.

**0** = No or doubtful.

☐

**1** = It is more difficult for the patient than usual to obtain orgasm and/or the experience of orgasm is slightly influenced.

☐

**2** = The patient states that there is a clear change in the ability to obtain orgasm and/or in the experience of orgasm. This change has reached such a degree that it troubles the patient.

☐

**3** = When the patient rarely or never can obtain orgasm and/or the experience of orgasm is markedly reduced.

☐

**4.16. Dry Vagina**

Dryness of vagina with sexual stimulation.

<b>0</b> = No or doubtful.	<input type="checkbox"/>
<b>1</b> = Slight dryness of vagina with sexual stimulation.	<input type="checkbox"/>
<b>2</b> = Moderately disturbing dryness of vagina with sexual stimulation.	<input type="checkbox"/>
<b>3</b> = Severely disturbing, marked dryness of vagina making coitus difficult (or necessitating the use of lubricants).	<input type="checkbox"/>

**4.17. Headache**

On the scoring sheet headache is classified as: a) tension headache, b) migraine, c) other forms of headache.

<b>0</b> = No or doubtful headache.	<input type="checkbox"/>
<b>1</b> = Slight headache.	<input type="checkbox"/>
<b>2</b> = Moderate, hampering headache which does not interfere with the patient's daily life.	<input type="checkbox"/>
<b>3</b> = Pronounced headache interfering with the patient's daily life.	<input type="checkbox"/>

**4.18. Physical Dependence**

Appearance of vegetative and/or other somatic symptoms after discontinuation of the drug in question, based on the condition during the last 3 months. Can be assessed only when an attempt has been made to discontinue the drug (indicate the responsible drug on the form).

<b>0</b> = Nothing suggests physical dependence.	<input type="checkbox"/>
<b>1</b> = After discontinuation there were slight vegetative symptoms like tachycardia or an increased tendency to sweating.	<input type="checkbox"/>
<b>2</b> = After discontinuation there were moderate to marked vegetative symptoms and anxiety or restlessness.	<input type="checkbox"/>
<b>3</b> = After discontinuation there were severe vegetative symptoms, anxiety, restlessness and/or convulsions.	<input type="checkbox"/>

**4.19. Psychic Dependence**

Psychic dependence is defined as a strong wish to continue taking the drug because of its psychic effects (or the effects which the patient thinks it has) when these effects are regarded by the doctor as being unwanted or at least unnecessary. Rating should be based on the condition during the last 3 months.

<b>0</b> = No or doubtful psychic dependence.	<input type="checkbox"/>
<b>1</b> = Slight, but not serious psychic dependence.	<input type="checkbox"/>
<b>2</b> = Clear psychic dependence, but without medical or social complications.	<input type="checkbox"/>
<b>3</b> = Pronounced psychic dependence with an almost compulsory wish to continue taking the drug at any price. The use of the drug in question may have caused medical or social complications.	<input type="checkbox"/>