

Treatment Plan for Adjustment Disorder

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|---|---------------------|
| First name: | Last name: |
| Date of birth: | Patient identifier: |
| Date: | |
| Adjustment disorder symptoms | |
| Feeling sad, hopeless, or not enjoying things one used to enjoy | |
| Avoiding important things such as going to work or paying bills | |
| Worrying or feeling anxious, nervous, jittery, or stressed out | |
| Difficulty functioning in daily activities | |
| Trouble sleeping | |
| Frequent crying | |
| Lack of appetite | |
| Difficulty concentrating | |
| Feeling overwhelmed | |
| Withdrawing from social supports | |
| Suicidal thoughts or behavior | |
| Patient's life stressors/changes | |
| | |
| Patient's current coping mechanisms | |
| | |
| Mental health and medical history | |
| | |

Current or past medication

Interventions

Additional notes

Clinician name:

Clinician's signature:

Clinician designation:

Date: