

Adjustment Disorder Assessment and Treatment Plan

Patient Information
Name:
Date of Birth:
Patient ID:
Date of Assessment:
Referring Clinician:
Assessment Information
Reason for Referral:
Duration of Symptoms:
Recent Life Changes/Stressors:
Current Symptoms:
Emotional Distress (e.g., sadness, hopelessness)
Anxiety (e.g., nervousness, worry)
Behavioral Changes (e.g., avoidance, aggression)
Physical Complaints (e.g., headaches, stomachaches)
Impact on Functioning
Social:
Occupational:
Educational:
Other Areas:
Diagnostic Criteria (Based on DSM-5/ICD-10)
1. Emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the stressor.
2. Symptoms are clinically significant as evidenced by one or both of the following:
a. Marked distress that is out of proportion to the severity or intensity of the stressor.
b. Significant impairment in social, occupational, or other important areas of functioning.
3. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting condition.

4. Symptoms do not represent normal bereavement.

5. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

Clinical Observations

Mental Status Exam:

Emotional Response:

Behavioral Observations:

Assessment Tools Used

Clinical Interview

Questionnaires/Scales

Specify:

Other Assessments

Specify:

Diagnosis

Primary Diagnosis: Adjustment Disorder (specify subtype):

Secondary Diagnoses (if any):

Treatment Plan

Goals

a.

b.

Interventions

1. Psychotherapy:

a. Type (e.g., CBT, supportive therapy):

b. Frequency:

2. Medication (if indicated):

a. Name:

b. Dosage:

c. Duration:

3. Lifestyle Modifications:

a. Stress Management Techniques:

b. Physical Activity Recommendations:

Supportive Measures

1. Social Support Enhancement:

2. Community Resources (support groups, workshops):

Follow-Up and Monitoring

Next Appointment:

Monitoring Schedule:

Adjustments to Plan Based on Progress:

Evaluating Clinician's Signature:

Date:

Patient Consent to Treatment Plan

I, _____, have discussed the assessment findings and treatment plan with the clinician. I understand the recommendations and consent to the proposed treatment plan.

Patient/Guardian's Signature:

Date: