

# PTSD Treatment Plan

First Name	Last Name	Date of Birth	Patient Identifier
Patient traumatic memory/images			
Patient triggers			
Current patient coping behaviors and mechanisms			
Select all PTSD symptoms that the patient has			
<input type="checkbox"/> Unwanted upsetting memories			
<input type="checkbox"/> Nightmares			
<input type="checkbox"/> Flashbacks			
<input type="checkbox"/> Inability to recall parts of memory			
<input type="checkbox"/> Exaggerated blame of self or others			
<input type="checkbox"/> Overly negative thoughts and assumptions about oneself or the world			
<input type="checkbox"/> Negative affect			
<input type="checkbox"/> Decreased interest in activities			
<input type="checkbox"/> Feeling isolated			
<input type="checkbox"/> Difficulty experiencing positive affect			
<input type="checkbox"/> Irritability or aggression			
<input type="checkbox"/> Risky or destructive behavior			
<input type="checkbox"/> Hypervigilance			
<input type="checkbox"/> Heightened startle reaction			
<input type="checkbox"/> Difficulty concentrating			
<input type="checkbox"/> Difficulty sleeping			
Medication			
Exposure therapy steps			
Additional interventions			
Clinician Name	Clinician Designation	Clinician Signature	Date