

# Treatment Plan for Adjustment Disorder

First Name	Last Name	Date of Birth	Patient Identifier
<b>Life stressors/changes</b>			
<b>Select all adjustment disorder symptoms that the patient has</b>			
<input type="checkbox"/> Feeling sad, hopeless or not enjoying things you used to enjoy		<input type="checkbox"/> Lack of appetite	
<input type="checkbox"/> Avoiding important things such as going to work or paying bills		<input type="checkbox"/> Difficulty concentrating	
<input type="checkbox"/> Worrying or feeling anxious, nervous, jittery or stressed out		<input type="checkbox"/> Feeling overwhelmed	
<input type="checkbox"/> Difficulty functioning in daily activities		<input type="checkbox"/> Withdrawing from social supports	
<input type="checkbox"/> Trouble sleeping		<input type="checkbox"/> Suicidal thoughts or behavior	
<input type="checkbox"/> Frequent crying			
<b>Coping Mechanisms</b>			
<b>Medication</b>			
<b>Mental Health History</b>			
<b>Interventions</b>			
Clinician Name	Clinician Designation	Clinician Signature	Date