

# Treatment Plan For Depression

Basic Information			
First Name	Last Name	Date of Birth	Patient Identifier (If known)
Gender	Preferred Pronouns	Email	Contact Number
Address		City	State Zip Code
Select any of the following depression-associated symptoms that the patient has <input type="checkbox"/> Depressed mood <input type="checkbox"/> Insomnia <input type="checkbox"/> Reduced self-esteem/confidence <input type="checkbox"/> Loss of interest or pleasure <input type="checkbox"/> Hypersomnia <input type="checkbox"/> Ideas of guilt or unworthiness <input type="checkbox"/> Significant weight loss/gain <input type="checkbox"/> Psychomotor agitation/retardation <input type="checkbox"/> Pessimistic thoughts of future <input type="checkbox"/> Reduced concentration/attention <input type="checkbox"/> Fatigue/Loss of energy <input type="checkbox"/> Suicidal act/attempt/ideation			
Treatment Plan			
Short term goals			
Long term goals			
Current sleeping patterns			
Current exercise patterns			
Medications			
Interventions			
Additional Notes			
Clinician Name	Clinician Designation	Clinician Signature	Date