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

- ☐ Depressed mood
- ☐ Loss of interest or pleasure
- ☐ Significant weight loss/gain
- ☐ Reduced concentration/attention
- ☐ Insomnia
- ☐ Hypersomnia
- ☐ Psychomotor agitation/retardation
- ☐ Fatigue/Loss of energy
- ☐ Reduced self-esteem/confidence
- ☐ Ideas of guilt or unworthiness
- ☐ Pessimistic thoughts of future
- ☐ 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