

PTSD Treatment Plan

First Name	Last Name	Date of Birth	Patient Identifier																		
Patient traumatic memory/images																					
Patient triggers																					
Current patient coping behaviors and mechanisms																					
<p>Select all PTSD symptoms that the patient has</p> <table border="0"> <tr> <td><input type="checkbox"/> Unwanted upsetting memories</td> <td><input type="checkbox"/> Negative affect</td> <td><input type="checkbox"/> Risky or destructive behavior</td> </tr> <tr> <td><input type="checkbox"/> Nightmares</td> <td><input type="checkbox"/> Decreased interest in activities</td> <td><input type="checkbox"/> Hypervigilance</td> </tr> <tr> <td><input type="checkbox"/> Flashbacks</td> <td><input type="checkbox"/> Feeling isolated</td> <td><input type="checkbox"/> Heightened startle reaction</td> </tr> <tr> <td><input type="checkbox"/> Inability to recall parts of memory</td> <td><input type="checkbox"/> Difficulty experiencing positive affect</td> <td><input type="checkbox"/> Difficulty concentrating</td> </tr> <tr> <td><input type="checkbox"/> Exaggerated blame of self or others</td> <td><input type="checkbox"/> Irritability or aggression</td> <td><input type="checkbox"/> Difficulty sleeping</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Overly negative thoughts and assumptions about oneself or the world</td> </tr> </table>				<input type="checkbox"/> Unwanted upsetting memories	<input type="checkbox"/> Negative affect	<input type="checkbox"/> Risky or destructive behavior	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Decreased interest in activities	<input type="checkbox"/> Hypervigilance	<input type="checkbox"/> Flashbacks	<input type="checkbox"/> Feeling isolated	<input type="checkbox"/> Heightened startle reaction	<input type="checkbox"/> Inability to recall parts of memory	<input type="checkbox"/> Difficulty experiencing positive affect	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Exaggerated blame of self or others	<input type="checkbox"/> Irritability or aggression	<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Overly negative thoughts and assumptions about oneself or the world		
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Medication																					
Exposure therapy steps																					
Additional interventions																					
Clinician Name	Clinician Designation	Clinician Signature	Date																		