

# 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>			
<div><div><ul style="list-style-type: none"><li><input type="checkbox"/> Feeling sad, hopeless or not enjoying things you used to enjoy</li><li><input type="checkbox"/> Avoiding important things such as going to work or paying bills</li><li><input type="checkbox"/> Worrying or feeling anxious, nervous, jittery or stressed out</li><li><input type="checkbox"/> Difficulty functioning in daily activities</li><li><input type="checkbox"/> Trouble sleeping</li><li><input type="checkbox"/> Frequent crying</li></ul></div><div><ul style="list-style-type: none"><li><input type="checkbox"/> Lack of appetite</li><li><input type="checkbox"/> Difficulty concentrating</li><li><input type="checkbox"/> Feeling overwhelmed</li><li><input type="checkbox"/> Withdrawing from social supports</li><li><input type="checkbox"/> Suicidal thoughts or behavior</li></ul></div></div>			
<b>Coping Mechanisms</b>			
<b>Medication</b>			
<b>Mental Health History</b>			
<b>Interventions</b>			
Clinician Name	Clinician Designation	Clinician Signature	Date