

Partners in Care

**YOUR PERSONAL PLAN:
Psychotherapy**

Patient Name: _____

Study ID: _____

CONTACT INFORMATION

Primary Care Clinician: _____ Tel. N°: _____

Depression Nurse Specialist: _____ Tel. N°:(____) _____

Psychotherapist: _____ Tel. N2:(____) _____

YOUR NEXT APPOINTMENTS

With Primary Care Physician: _____ *Date* */ /* *Time:* - _____ *(circle one)*
am / pm

With Psychotherapist: _____ *Date* */ /* *Time:* - _____ *(circle one)*
am / pm

SYMPTOMS TO MONITOR

V if you are having this symptom:

- Anxiety attacks
- Aches and pains
- Problems with sleep
- Trouble thinking, concentrating, or deciding
- Decreased or increased appetite
- Feeling slowed down or sped up/irritery
- Feelings of worthlessness or guilt
- Wishing you were dead or thinking about suicide*
- Feeling depressed or sad
- Loss of interest or pleasure
- Nervousness or tension
- Fatigue or loss of energy
- Others: _____

YOUR QUESTIONS/CONCERNS

Bring this form to your next visit. Record any questions, problems, or concerns you may have about your current treatment here:
