

Partners in Care

**YOUR PERSONAL PLAN:  
Watchful Waiting**

*(For patients not started on medication or psychotherapy treatment plan)*

**Patient Name:**

**Study ID:**

CONTACT INFORMATION

|   |                       |
|---|-----------------------|
| <b>Primary Care Physician:</b> _____      | Tel. N° : _____       |
| <b>Depression Nurse Specialist:</b> _____ | Tel. N2:(     ) _____ |
| <b>Psychotherapist:</b> _____             | Tel. N° : _____       |

YOUR NEXT APPOINTMENTS

|  |   |   |
|--|---|---|
| <b>With Primary Care Physician:</b>      | <i>Date</i> <u>    </u> / <u>    </u> / <u>    </u> | <i>Time:</i> <u>    </u> . <u>    </u> <small>(circle one)</small><br>am / pm |
| <b>With Depression Nurse Specialist:</b> | <i>Date</i> <u>    </u> / <u>    </u> / <u>    </u> | <i>Time:</i> <u>    </u> am / pm  |
| <b>With:</b>                             | <i>Date</i> <u>    </u> / <u>    </u> / <u>    </u> | <i>Time:</i> <u>    </u> am / pm  |

SYMPTOMS TO MONITOR

|  |  |
|--|--|
| <input checked="" type="checkbox"/> <b>if you are having this symptom:</b> |  |
| <input type="checkbox"/> Anxiety attacks                                   | <input type="checkbox"/> Wishing you were dead or thinking about suicide |
| <input type="checkbox"/> Aches and Pains                                   | <input type="checkbox"/> Feeling depressed or sad                        |
| <input type="checkbox"/> Problems with sleep                               | <input type="checkbox"/> <i>Loss of</i> interest or pleasure             |
| <input type="checkbox"/> Trouble thinking, concentrating, or deciding      | <input type="checkbox"/> Nervousness or tension                          |
| <input type="checkbox"/> Decreased or increased appetite                   | <input type="checkbox"/> Fatigue or loss of energy                       |
| <input type="checkbox"/> Feeling slowed down or sped up/jittery            | <input type="checkbox"/> Others: _____                                   |
| <input type="checkbox"/> Feelings of worthlessness or guilt                | _____  |

YOUR QUESTIONS/CONCERNS

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

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