

END OF TREATMENT FORM

Name: _____ Date: _____

Complete this form with your provider to help you make a plan for remaining well after the completion of the treatment.

1. Depression maintenance and prevention. What are the activities that make you feel good and you want to continue to stay well?

2. Identify triggers. Which situations can increase your risk of a depression episode in the future?

In these situations, what are the activities you may start doing again which will make you feel worse?

What will help you to do the things that will make you feel better?

Step 5: Identify barriers and solutions: _____

On a scale of 0-10, how committed and confident are you that you can achieve your goal?



Client's Signature

Date