CBT Depression Treatment Plan Template

Page 1 of 3 · Blank formulation-to-plan fields. Educational only for licensed or supervised mental-health clinicians. Adapt to presentation, risk, culture, and setting.

Client / ID: Date:

Clinician / credential: Plan number / review date:

1. Clinical impression, rule-outs, risk

- ☐ MDD single
- ☐ MDD recurrent
- ☐ PDD / other:
- ☐ Low risk
- ☐ Elevated risk
- ☐ Safety plan on file

2. Presenting concern (client language)

3. Primary maintaining cycle this course

- ☐ Withdrawal / anhedonia
- ☐ Rumination
- ☐ Self-criticism
- ☐ Hopelessness
- ☐ Relapse risk
- ☐ Mixed primary:

Cue / trigger:

Prediction / meaning:

Avoidance, rumination, or self-attack:

Short-term payoff:

Long-term cost:

4. Client-owned long-term goal

5. SMART objectives (3 to 4; activity + prediction/process + relapse where fit)

1.

2.

3.

4.

6. Named interventions and stage order

Baseline / shared formulation:

Primary stage (often activation when withdrawal dominates):

Cognitive / rumination work from action data:

Generalization / relapse map / step-down:

7. Homework done-state, barrier plan, measures

What "done" looks like this week:

Barrier to plan for:

PHQ-9 baseline: Target band: Re-score cadence:

Functional / process measure (activity log, etc.):

Planned reformulation trigger / formal review date:

8. Relapse signatures, early response, signatures

Relapse signatures (3):

First recovery actions:

Clinician signature: Client signature (if used):

CBT Depression Treatment Plan Template

Client: M.K. · Date: 2026-07-18 · Clinician: Hannah Lin, counseling psychologist · Plan: Initial review after third episode

Presenting concern

"I know this pattern. I disappear for weeks, cancel the people who still call, and tell myself it is permanent again."

Clinical impression and risk

MDD, recurrent, moderate (F33.1 range; verify billable code). No current suicidal plan; passive death wishes denied this week. Safety plan updated at intake. Prior CBT response in episode two. Rule out bipolar spectrum, sleep apnea, and medication contribution with PCP as needed.

CBT formulation

Cue: unstructured weekend + canceled friend plan. Prediction: "I always relapse, so starting will not matter." Maintaining behavior: bed, rumination on prior episodes, cancel remaining contact. Short-term relief from avoiding effort keeps reward low and strengthens the permanence prediction.

Problem list

1) Weekend days with no out-of-bed structure before noon. 2) Cancellation of remaining social contact when mood dips. 3) Rumination on prior episodes that blocks one recovery action. 4) Self-discounting of partial recovery steps ("it never lasts").

Long-term goal

Client keeps a stable weekend morning routine, protects one weekly contact, and uses a written early-response plan at the first relapse signature without waiting for full collapse.

SMART objectives

1) Within 2 weeks: 7-day activity/mood monitoring + one 15-min scheduled task on 5 of 7 days, including one weekend morning block. 2) Within 6 weeks: graded activation schedule of 8 to 10 items; at least 70% completion for two consecutive weeks. 3) Within 10 weeks: four prediction tests on "I always relapse" with written expectancy vs outcome. 4) PHQ-9 every 2 weeks; non-response discussion if score has not moved at least 3 points or activation adherence under 50% at planned review. Name 3 relapse signatures and first recovery action by session 10.

Stage order and interventions

Baseline: risk review, shared formulation, PHQ-9, activity monitoring. Primary activation: graded schedule + barrier planning; light rumination interruption only when it blocks the next task; hold heavy cognitive restructuring until monitoring data exist. Cognitive work from action data: permanence and self-critical predictions; behavioral experiments. Generalization: relapse signatures, early-response plan, taper or booster.

Homework done-state and measures

Each week: one reviewable activation block or experiment with time, place, and review question. PHQ-9 every 2 weeks; weekly activity log. Item 9 informs risk review and is not a complete suicide-risk assessment. Safety plan on file.

Review trigger and step-down

Formal review at mid-course checkpoint (often around session 6 in a 12 to 16 session arc). Reformulate if PHQ-9 flat and adherence under 50%, homework becomes self-punitive, risk rises, or formulation no longer explains the week. Step-down when activation schedule holds two weeks at agreed adherence, PHQ-9 in target band, and client can name first three early-response steps.

Signatures: Clinician _____ **Client** _____

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Stage review snapshot

Review date: Active stage now:

PHQ-9 then to now: Activation / homework adherence %:

Primary cycle still correct? Y / N / revise to:

Non-response / reformulation checkpoint

At the planned review, do not default to "more of the same." Check each box that applies, then name the next decision.

- ☐ Symptom or functional measures flat at planned review
- ☐ Activation adherence low because task is too large, poorly timed, or shame-inducing
- ☐ Cognitive worksheets functioning as self-punishment
- ☐ Active risk or rapid deterioration !' safety planning first
- ☐ Possible bipolarity, psychosis, substance, sleep, or medical contributors need evaluation
- ☐ Trauma flooding or environmental danger makes standard cognitive challenge inappropriate
- ☐ Formulation no longer explains the client's week

Next clinical decision (stay / revise cycle / pause / coordinate care):

Relapse signatures (client language)

Example from the worked composite: sleeping past 11 a.m. two weekend days; canceling the weekly contact; replaying "this never ends." Write the client's three.

Signature 1:

Signature 2:

Signature 3:

Early-response map (first recovery actions)

Example: open the activity card !' one 15-minute block before noon !' text the protected contact one factual check-in !' bring the card to the next session.

Action 1 (time + place):

Action 2 (contact or environment):

Action 3 (bring to next session):

Booster / step-down plan

Booster timing or step-down criteria met?

What stays in the client's written map after discharge:

Boundaries

For licensed or supervised mental-health clinicians only. Educational and adaptable. Not a diagnosis instrument, risk instrument, or official APA / NICE / payer form. Local standards, supervision, and coordinated care remain controlling. PHQ-9 item 9 informs risk review; it is not a complete suicide-risk assessment.