Anxiety Nursing Care Plan

Patient Name:

Date:

Assessment

- Symptoms: [Describe the patient's anxiety symptoms, including severity, duration, and
  impact on daily life.]

- History: [Gather information about the patient's past history of anxiety, including any
  previous diagnoses, treatments, and response to treatment.]

- Risk Factors: [Identify any potential risk factors for anxiety, such as family history, genetic
  predisposition, stressful life events, or substance abuse.]

Diagnosis

- Diagnosis: [Determine if the patient meets the diagnostic criteria for an anxiety disorder
  based on established classification systems like the DSM-5 .]

- Type of Anxiety Disorder: [Specify the type of anxiety disorder, such as generalized anxiety disorder, panic disorder, or social anxiety disorder.]

Planning

- Goals: [Establish clear, measurable, achievable, relevant, and time-bound (SMART) goals
  for treatment.]

- Interventions: [Outline a range of interventions, considering both non-pharmacological
  and pharmacological approaches.]