

7-Column Thought Record

Date: _____ dd / mm / yyyy Name: _____

Physician's Name: _____

Situation/Trigger - What happened? Where? When? Who with? How did it happen?

Feelings/Body Sensations - Rate your emotions from 0 to 100. What did I feel during that time? How intense were the emotions? What did I notice and feel in my body?

Unhelpful Thoughts/Images - What went through my mind, and which of them disturbed me? What did they mean/say about me or the situation? What am I responding to?

Facts Supporting Unhelpful Thoughts

Facts Opposing Unhelpful Thoughts

Alternative Thoughts - What would someone else say about this situation? What advice would I give someone else? Is there another way of seeing it? Is my reaction proportional to the actual event?

Outcome - Re-rate your emotions from 0-100. What could I do differently? What would be more effective? What will be more helpful to me/situation? What are the consequences of doing these?