Thought Stopping Worksheet

Date: _____ dd / mm / yyyy Name: _____

Relevant medical information (if needed):

SITUATION 1

Situation/trigger:

Automatic negative thought:

Evidence supporting negative thought:

Evidence against negative thought:

Alternate positive thought:

SITUATION 2

Situation/trigger:

Automatic negative thought:

Evidence supporting negative thought:

Evidence against negative thought:

Alternate positive thought:

SITUATION 3

Situation/trigger:

Automatic negative thought:

Evidence supporting negative thought:

Evidence against negative thought:

Alternate positive thought:

Notes: