TREATMENT PLAN

Client's Name: _____ D.O.B._____

Date of Initial Session: _____ Anticipated Length of Therapy: _____

Therapist's Name: _____

Phone Number: _____

Type of Therapy (Individual, Group, Couples, Family): _____

DSM Diagnosis

Code Number and Title	Presenting Target Symptoms (Including Duration)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Presenting Problem

_____

_____

_____

_____

Objective 1

_____

_____

_____

Strategies

_____

_____

_____

Method of Assessment

_____

_____

_____

Notes

_____

_____

_____

Objective 2

_____

_____

_____

Strategies

_____

_____

_____

Method of Assessment

_____

_____

_____

Notes

_____

_____

_____

Objective 3

_____

_____

_____

Strategies

_____

_____

_____

Method of Assessment

_____

_____

_____

Notes

_____

_____

_____

Objective 4

_____

_____

_____

Strategies

_____

_____

_____

Method of Assessment

_____

_____

_____

Notes

_____

_____

_____

Signature of Therapist: _____ Date: _____