Treatment Plan

Name: DOB: Today's Date:

Presenting Problem/Symptom:

Long Term Goals:

1.
2.
3.
4.

Short Term Goals/Objectives:	Date Established:	Projected Completion:	Achieved:
1.			
2.			
3.			
4.			
5.			
6.			

Interventions/Actions:

Strengths/Resources:

Notes:

Client Signature Date Therapist/Provider Signature Date