

# Treatment Plan

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Medications: \_\_\_\_\_

Frequency of Sessions: \_\_\_\_\_ Observations: \_\_\_\_\_

Presenting Problem/Symptom: \_\_\_\_\_

## Long Term Goals:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

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

Interventions/Actions: \_\_\_\_\_

## Strengths/Resources:

\_\_\_\_\_

Client Signature \_\_\_\_\_ Date \_\_\_\_\_ Therapist/Provider Signature \_\_\_\_\_ Date \_\_\_\_\_