

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. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 2. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 3. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 4. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 5. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 6. <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Interventions/Actions:

Strengths/Resources:

Notes:

Client Signature

Date

Therapist/Provider Signature

Date