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:
1.				
2.				
3.				
4.				
5.				
6.				

Interventions/Actions:

Strengths/Resources:

Client Signature	Date	Therapist/Provider Signature	Date