



Treatment Plan

The Treatment Plan should address the client's needs, diagnosis and impairments as documented in the Initial Assessment. All treatment objectives must be **measurable and observable**. All interventions must include **frequency and duration**. The treatment plan is to be developed with the client, and the client's understanding of the treatment plan is to be documented in the medical record.

Client Name:
DOB:

Treatment Objectives (indicate how each will be measured/observed. i.e. "as evidenced by") Put an "X" next to agreed on objectives.

	Treatment Objectives	To be measured/observed by:
	Reduce risk factors (as specified on Initial Assessment)	
	Reduce symptoms (list specific symptoms)	
	Decrease impairments (list specifics)	
	Develop coping skills to deal with stress	
	Stabilize (short term) crisis	
	Maintain (long term) Stabilization of Symptoms	
	Psychotropic medication referral to:	
	Physical Health Care referral to:	
	Other (describe):	
	Other (describe):	

Strengths (indicate how client's strengths will be applied to assist in reaching treatment objectives):

Planned Interventions-Client Participation (Must be consistent with treatment objectives. Must include frequency/duration.)
Check all that apply.

Type of Intervention	Frequency/Duration	Type of Intervention	Frequency/Duration
Individual Therapy		Solution Focused Techniques	
Anger Management		Stress Management	
Cognitive Behavioral Interventions		Medication Management	
Grief Work		Assertiveness Training	
Relaxation training		Other:	
Parent training		Other:	
Teach skills of:		Other:	
Planned referrals:		Other:	

My therapist and I have developed this plan together, and I am in agreement to working on these issues and objectives. I understand the plan that was developed for my treatment.

Client's Signature:	Date:
Parent's Signature (for minors):	Date:
Provider's Signature (include credential):	Date: