**CLIENT TREATMENT PLAN**

**Client Name: D.O.B: Date:**

| **Strengths & Resources:** |  |
| --- | --- |
| **Client’s Strengths & Resources:** *List client’s strengths and community resources.* |  |
| **Problem:** |  |
| **Primary Diagnosis:***List ICD-9/10 code(s) and written diagnosis if applicable.* |  |
| **Secondary Diagnosis:***List ICD-9/10 code(s) and written diagnosis if applicable.* |  |
| **Problem Narrative:***List supporting symptoms to support DSM diagnosis criteria.*  |  |
| **Problem Statement:***Write the problem statement in the client’s own words.* |  |
| **Goal(s):** *Goal Statement in Client’s words.* | **Objective(s):** *Action steps the client and/or family member(s) will take measured by frequency, duration & amount.*  | **Intervention(s):** *Actions the therapist will take measured by frequency, duration and amount.*  | **Target Date:** | **Date Achieved & Resolution/ Outcome** |
| **1.**  |  |  |  |  |
| **2.** |  |  |  |  |
| **3.** |  |  |  |  |

I understand and agree to the goals and services outlined above, and I have participated in the development of this treatment plan.

| **Name:** | **Signature:** | **Date:** |
| --- | --- | --- |
| **TYPE CLIENT NAME** |  |  |
| **TYPE FAMILY MEMBER NAME** |  |  |
| **TYPE LEGAL GUARDIAN NAME** |  |  |
| **Therapist’s Signature: Date:** |

YOUR PRINTED NAME & CREDENTIALS