**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