Treatment Plan

Client Name:_____

Please rate each concern on a scale of 1-10 with 1 being the mildest symptom, 10 being the worst, and 0 being no symptoms.

___ADD/ADHD	___Anger Issues	___Anxious Mood
___Dependency	___Depressed Mood	___Employment Stressors
___Financial Stressors	___Grief	___Manic Symptoms
___Medical Problems	___ Obsessive Compulsive Behaviors	___Phobias
___Racing Thoughts	___Relational Conflict	___Sexual Abuse
___Sleep difficulties	___Substance Abuse/Dependency	___Other_____

___Child-behavior problems at school ___Child-disobeying at home ___Child-low grades at school

Other concerns not listed above/ specific symptoms of concern:

_____

_____

Goals for counseling:

_____

_____

_____

Interventions:

___Assertiveness training ___Anger Management ___Cognitive Restructuring ___Grief therapy ___Problem Solving ___Stress Management ____Solution Focused ___ Psychoeducation/Skills training ___ Individual therapy ___ Couples therapy ___ Family therapy

I acknowledge my participation in the development of this treatment plan.

Client Signature	**Date**	**Review plan date**	**Client Signature for review**	**Date**
Other Signature	**Date**	**Review plan date**	**Other Signature for review**	**Date**
Therapist	**Date**	**Review plan date**	**Therapist**	**Date**