



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.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Anger Issues | <input type="checkbox"/> Anxious Mood | <input type="checkbox"/> Emotional/Verbal abuse |
| <input type="checkbox"/> Dependency | <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Employment Stressors | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Financial Stressors | <input type="checkbox"/> Grief | <input type="checkbox"/> Manic Symptoms | <input type="checkbox"/> Life transition |
| <input type="checkbox"/> Medical Problems | <input type="checkbox"/> Obsessive Compulsive Behaviors | <input type="checkbox"/> Phobias | |
| <input type="checkbox"/> Racing Thoughts | <input type="checkbox"/> Relational Conflict | <input type="checkbox"/> Sexual Abuse | |
| <input type="checkbox"/> Sleep difficulties | <input type="checkbox"/> Substance Abuse/Dependency | <input type="checkbox"/> Physical Abuse | 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 and that I am seeking services through a provider who does not accept insurance outside of what is available to me via my insurance plan if applicable.

Client Signature

Date

Client Signature for review

Date

Other Signature

Date

Other Signature for review

Date

Matt Slavsky, LCSW, Therapist

Date

Review plan date

Review plan date

Review plan date