



# 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"/> Dependency                        | <input type="checkbox"/> Depressed Mood                 | <input type="checkbox"/> Employment Stressors       |
| <input type="checkbox"/> Financial Stressors               | <input type="checkbox"/> Grief                          | <input type="checkbox"/> Manic Symptoms             |
| <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"/> Other _____                |
| <input type="checkbox"/> Child-behavior problems at school | <input type="checkbox"/> Child-disobeying at home       | <input type="checkbox"/> 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