



IMAGINE. ACHIEVE. CONQUER.

TREATMENT PLAN
(This form is optional. You may use your own treatment plan form.)
Please type or print legibly.

Client's Name Age Employer

Clinician's Name Date

DIAGNOSES:

Table with 2 columns: ICD 10#, Description

TARGET PROBLEMS/SYMPTOMS:

SEVERITY OF SYMPTOMS:

Table with 4 columns: Target Problems/Symptoms, Mild, Moderate, Severe

Functional Impairment:

TREATMENT OBJECTIVES:

SPECIFIC INTERVENTIONS:

- 1. 2. 3. (for both objectives and interventions)

Intervention Plan/Time Frame:

Blank lines for intervention plan details

Prognosis: Excellent Good Fair Guarded Poor

Projected Number of Visits Projected Discharge Date

Counselor Signature Date