Individual Treatment Plan

Today's Date:
Client name:
DOB:
Location of treatment:
Treatment provider:

ICD-10 Diagnosis: 1. 2. 3.
Symptoms that are the focus of treatment (check all that apply): ❑ Anxiety ❑ Depression ❑ Trauma ❑ Adjustment issues ❑ Relationship problems ❑ Self-esteem issues ❑ Mood swings ❑ Addiction problems ❑ Decision making problems ❑ Other: ❑ Other: ❑ Other:

Goal #1:
Intervention:
Intervention:
Intervention:

Goal #2:
Intervention:
Intervention:
Intervention:
Goal #3:
Intervention:
Intervention:
Intervention:

Planned frequency of treatment:
Other agencies/persons involved (with signed releases obtained):
Provider Signature:
Date:

Annual Review -- Completed on:
Summary of progress: Goals remain in place for additional year? Yes / No (complete new tx plan)