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Treatment Plan - Initial

Client: _____ DOB: _____ Age: _____ Today's Date: _____

Treatment Modality:

Adult _____ Child _____ Adolescent _____ Couple _____ Family _____ Group _____

Multidisciplinary Coordination/Medications/Treatments:

Name/Role _____ Phone _____ Fax _____ Release Y/N

Name/Role _____ Phone _____ Fax _____ Release Y/N

Name/Role _____ Phone _____ Fax _____ Release Y/N

Suicidal Risk: None __ Low __ Medium __ High __

Homicidal Risk: None __ Low __ Medium __ High __

Medications _____ Diagnosis: _____ Dose _____ How Long Taking? _____

Medications _____ Diagnosis: _____ Dose _____ How Long Taking? _____

Medications _____ Diagnosis: _____ Dose _____ How Long Taking? _____

Short-term Goals:

Interventions:

Interventions: _____

Long-term Goals:

Referrals: _____

Frequency of visits: _____

Additional Information:

