Treatment plan

Built together with the client

Client name or ID

Date of plan

Next review date

Clinician

Diagnosis or clinical focus (clinician determined)

Planned services ☐ Individual ☐ Couple ☐ Family ☐ Group

Frequency and length of sessions

Expected duration or review point

Client strengths and supports

Barriers and how we will address them

Focus area 1

Concern, in the client's words

Long term goal

Measurable objective	Target date	Status

Interventions the clinician will use

What the client will do

Focus area 2

Concern, in the client's words

Long term goal

Measurable objective	Target date	Status

Interventions the clinician will use

What the client will do

Client voice: what matters most to me about this plan, and how I will know it is working

Add more focus areas on extra copies of this page. Revisit the plan whenever goals, risk or circumstances change.

Client signature and date

Clinician signature, credentials and date

Treatment plan review

Check progress, adjust the plan

Client name or ID

Review date

Sessions since last review

Progress on each goal

Goal or objective	Starting rating (0 to 10)	Current rating (0 to 10)	Status	Notes

Status: met, progressing, little change, revised, discontinued. Use the same 0 to 10 meaning each time, such as how much the concern affects daily life.

What is helping

What is getting in the way

Client feedback on therapy and the relationship

Changes in risk, health, medication or life circumstances

Review decision ☐ Continue as written ☐ Update goals ☐ Change frequency ☐ Change modality ☐ Refer or coordinate care ☐ Plan to end therapy

Updates to goals, interventions and frequency

Next review date

Next appointment

Client signature and date

Clinician signature, credentials and date

L&T

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