Family Guidance Centers

Treatment Plan

(Original Plan and/or Revisions)

Patient Name:_____

Patient Date of Birth: _____ / _____ / _____

Date: _____ / _____ / _____

Clinician Name: _____

Presenting Problem/Symptoms:

Life Stressors: ☐ Relationship Stress ☐ School or Work Stress ☐ Caregiver Stress ☐ Financial Stress ☐ Environmental Stress ☐ Grief and Loss ☐ Illness or Injury ☐ Lack of Support ☐ Traumatic Event(s) ☐ Trauma History ☐ Other:

Goal 1:

Long Term Treatment Goal:

Treatment Objective/Short-Term Goals:

Targeted Completion Date:

Treatment Modality: ☐ Individual ☐ Family ☐ Other: _____

Treatment Frequency:

Number of Sessions: Frequency of Sessions: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other _____

Goal 2:

Long Term Treatment Goal:

Treatment Objective/Short-Term Goals:

Targeted Completion Date:

Treatment Modality: ☐ Individual ☐ Family ☐ Other: _____

Treatment Frequency:

Number of Sessions: Frequency of Sessions: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other _____

Goal 3:

Long Term Treatment Goal:

Treatment Objective/Short-Term Goals:

Targeted Completion Date:

Treatment Modality: ☐ Individual ☐ Family ☐ Other: _____

Treatment Frequency:

Number of Sessions: Frequency of Sessions: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other _____

Interventions:

☐ Behavioral Assessment	☐ Support Group	☐ Parent Training	☐ PCP Coordination
☐ Safety Planning	☐ School Consultation	☐ Behavioral Contracting	☐ Play Therapy
☐ Relapse Prevention	☐ Psychotropic Medication	☐ Case Management	☐ Supportive Therapy
☐ Cognitive Restructure	☐ Identify/Express Affect	☐ CD Assess/Treatment	☐ Journaling
☐ Relaxation Training	☐ Social Skills	☐ Psychoeducation	☐ Other _____

Add'l Notes:

Clinician Signature _____ Date _____