



## Treatment Plan

Client Name: \_\_\_\_\_ Chart #: \_\_\_\_\_

### A. Diagnosis

Initial Treatment Plan     30-Day Review

ICD-10: \_\_\_\_\_ Description:

ICD-10: \_\_\_\_\_ Description:

ICD-10: \_\_\_\_\_ Description:

Diagnostic Justification and/or Assessment Measures:

### B. Presenting Problem (s)

1.

2.

3.

### C. Treatment Goals

1.

2.

3.

### D. Objective

1.

2.

3.

### E. Treatment Strategy & Interventions:

F. Estimated Completion:     1-3 Months     4-7 Months     8-12 Months

G. Frequency of Treatment:     Twice per Week     Weekly     Every 2 Weeks     Monthly

Signature

Relationship to Client

Date

Provider's Signature

Name

Date

Continued On Back



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**ADDITIONAL INFORMATION:**

Patient Name

Therapist Name

Date