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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

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