**Treatment Plan** for (Client Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The Treatment Plan should address the client’s needs, diagnosis and impairments as documented in the Initial Assessment. All treatment objectives must be* ***measurable and observable.*** *All interventions must include* ***frequency and duration.*** *The treatment plan is to be developed with the client, and the client’s understanding of the treatment plan is to be documented in the medical record.*

**Treatment Objectives** (indicate how each will be measured/observed. i.e. “as evidenced by”)

|  |  |  |
| --- | --- | --- |
| Put an “X” next to agreed on Objectives | Treatment Objectives | To be measured/observed by: |
|  | Reduce Risk Factors (as specified on Initial Assessment) |  |
|  | Reduce symptoms (list specific sxs) |  |
|  | Decrease impairments (list specifics) |  |
|  | Develop coping skills to deal with stress |  |
|  | Stabilize (short term) crisis |  |
|  | Maintain (long term) Stabilization of Symptoms |  |
|  | Psychotropic medication referral to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | Physical Health Care referral to:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | Other (describe): |  |
|  | Other (describe): |  |

**Strengths** (indicate how client’s strengths will be applied to assist in reaching treatment objectives):

**Planned Interventions-Client Participation** (Must be consistent with treatment objectives. Must include frequency/duration. Check all that apply.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Type of Intervention | Frequency/Duration |  | Type of Intervention | Frequency/Duration |
|  | Individual Therapy |  |  | Solution Focused Techniques |  |
|  | Anger Management |  |  | Stress Management |  |
|  | Cognitive Behavioral Interventions |  |  | Medication Management |  |
|  | Grief Work |  |  | Assertiveness Training |  |
|  | Relaxation training |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | Parent training |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | Teach skills of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | Planned referrals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

My therapist and I have developed this plan together, and I am in agreement to working on these issues and objectives. I understand the plan that was developed for my treatment.

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Signature: (for minors)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider’s Signature (include credential): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please note: The County of San Diego Behavioral Health Services created this document as a sample tool to assist providers in documentation. The County does not require the use of this document, nor are we collecting the information contained herein.*