

TREATMENT PLAN

MODALITY:

CLIENT NO.:	CLIENT NAME:	DSM CODE:
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Review previous Treatment Plan & Progress Notes, if any. Carry forward all problems. Use original date on old problems. Use Index Number for each problem/goal/plan. 1 = Drug Use; 2 = Medical; 3 = Legal; 4 = Psychosocial; 5 = Educational; 6 = Employment/Vocational; 7 = Financial 8 = Discharge

Index #	Date Identified.	Statement of Problem	Statement of Goal	Action Steps/Responsible Staff Member/	Target Date	Date Target Closed

Frequency of Counseling	Individual _____ x	(Circle) weekly or monthly	Group _____ x	(Circle) weekly or monthly
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Counselor's Signature:	Date:	Client Signature:	Date:
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Supervising Counselor's Signature:	Date:	Physician's Signature:	Date:
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