TREATMENT PLAN FORM

1. Name (Last, First, Middle)	2. Date of Birth	3. ID#
4. Treatment Provider:	5. Counselor/Therapist	
6. DSM-5 Diagnosis(es) a.		
7. Is Patient's Physical Exam Available? ☐ If yes, provide date the physical exam was completed ☐ If no, provide the date of scheduled exam appointment		
8. Assessment Date:	9. Updated Treatment Plan Date:	

PROBLEM #1			
10. Problem Statement			
11. Goal			
12. Context Issues:	13. Strengths, Abilities, and Preferences:		
14. Treatment Plan Start Date:	15: Dimension(s) and Severity:		
Short-Term Goals (SMART Objectives)	(A)Action Steps or (I) Interventions	Target Date	Status