**TREATMENT PLAN**

|  |  |
| --- | --- |
| **Client Name:** Click here to enter text. | **PACTS No.** Click here to enter text. |
| **Provider Name:** Click here to enter text. | **Counselor Name:** Click here to enter text. |
| **Plan Type:**  Initial  Update | **Date:** Click here to enter a date. |

**DIAGNOSIS AND ACUITY:**

|  |
| --- |
| Click here to enter text. |

**PROGNOSIS:**

|  |  |  |  |
| --- | --- | --- | --- |
| Poor | Fair | Good | Excellent |

**STAGE OF CHANGE:** if applicable

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Precontemplation | Contemplation | Preparation | Action | Maintenance |

**RISK FACTORS:**

|  |
| --- |
| Click here to enter text. |

**PROTECTIVE FACTORS:** (things that minimize risk, e.g. strong social supports, positive attitude and outlook, etc.)

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| --- |
| Click here to enter text. |

**CLIENT SUPPORTIVE SOCIAL NETWORKS/FAMILY INVOLVEMENT:**

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| --- |
| Click here to enter text. |

**INDIVIDUALIZED AND CULTURAL CONSIDERATIONS:**

The counselor is aware and/or responsive to the following areas in the selection of treatment interventions:

|  |  |  |  |
| --- | --- | --- | --- |
| Low Intelligence | Physical Handicap | Reading/Writing Limitations | Trauma |
| No Desire to Change | Homeless | Transportation | Childcare |
| Language | Ethnicity | History of Abuse/Neglect | Interpersonal Anxiety |
| Other: Click here to enter text. | | | |

**TREATMENT RELATED GOALS:** specific (not vague), measurable (quantifiable), achievable (realistic), relevant (treatment related), and time-bound (start, incremental and attainment)

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| --- |
| Click here to enter text. |

**ACTION STEPS:** to include appropriate type and frequency of continued treatment

|  |
| --- |
| Click here to enter text. |

**INTERVENTIONS USED TO SUPPORT TREATMENT RELATED GOALS:** (check all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| Cognitive Challenging | Cognitive reframing | Communication skills | Behavioral rehearsals |
| Symptom management | Problem solving | Substance testing | Impulse control |
| Effective communication and conflict resolution | Expanding coping patterns and skills | Client’s ability to identify accessible community support systems | Relapse prevention planning |
| Other: Click here to enter text. | Involvement in Mutual Support Programs | Prosocial Support | Trauma-informed interventions |

**MEDICATION MANAGEMENT PLAN:** (when applicable, to include adherence to medication)

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| --- |
| Click here to enter text. |

**COLLABORATION/COORDINATION FOR COMMUNITY BASED SERVICES:**

|  |
| --- |
| Click here to enter text. |

**ACQUIRED SKILLS FOR MANAGING RISK/SYMPTOMS AND SELF-MANAGEMENT:**

|  |
| --- |
| Click here to enter text. |

**COUNSELOR RECOMMENDATION AND JUSTIFICAITON FOR CONTINUED TREATMENT SERVICES:**

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| --- |
| Click here to enter text. |

Counselor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click here to enter a date.

I have participated in developing my current treatment goals. I agree with the content of my plan and understand how often I am expected to attend services. My counselor has provided me a copy of the treatment plan.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click here to enter a date.

**An individualized, updated treatment plan outlining the ongoing evaluation of symptoms and progress in treatment should be typed and sent to assigned officer at least every 90 days.**