

TREATMENT PLAN

Client Name:	PACTS No.
Provider Name:	Counselor Name:
Plan Type: <input type="checkbox"/> Initial <input type="checkbox"/> Update	Date:

DIAGNOSIS AND ACUITY:

PROGNOSIS:

<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Good	<input type="checkbox"/> Excellent
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STAGE OF CHANGE: if applicable

<input type="checkbox"/> Precontemplation	<input type="checkbox"/> Contemplation	<input type="checkbox"/> Preparation	<input type="checkbox"/> Action	<input type="checkbox"/> Maintenance
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RISK FACTORS:

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

CLIENT SUPPORTIVE SOCIAL NETWORKS/FAMILY INVOLVEMENT:

INDIVIDUALIZED AND CULTURAL CONSIDERATIONS:

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

<input type="checkbox"/> Low Intelligence	<input type="checkbox"/> Physical Handicap	<input type="checkbox"/> Reading/Writing Limitations	<input type="checkbox"/> Trauma
<input type="checkbox"/> No Desire to Change	<input type="checkbox"/> Homeless	<input type="checkbox"/> Transportation	<input type="checkbox"/> Childcare
<input type="checkbox"/> Language	<input type="checkbox"/> Ethnicity	<input type="checkbox"/> History of Abuse/Neglect	<input type="checkbox"/> Interpersonal Anxiety

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

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

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

<input type="checkbox"/> Cognitive Challenging	<input type="checkbox"/> Cognitive reframing	<input type="checkbox"/> Communication skills	<input type="checkbox"/> Behavioral rehearsals
<input type="checkbox"/> Symptom management	<input type="checkbox"/> Problem solving	<input type="checkbox"/> Substance testing	<input type="checkbox"/> Impulse control
<input type="checkbox"/> Effective communication and conflict resolution	<input type="checkbox"/> Expanding coping patterns and skills	<input type="checkbox"/> Client's ability to identify accessible community support systems	<input type="checkbox"/> Relapse prevention planning
<input type="checkbox"/> Other:	<input type="checkbox"/> Involvement in Mutual Support Programs	<input type="checkbox"/> Prosocial Support	<input type="checkbox"/> Trauma-informed interventions

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

COLLABORATION/COORDINATION FOR COMMUNITY BASED SERVICES:

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

COUNSELOR RECOMMENDATION AND JUSTIFICATION FOR CONTINUED TREATMENT SERVICES:

Counselor Signature: _____

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:

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.