Practice/Practitioner Name
Address
Phone/Email

TREATMENT PLAN

Client(s) Name(s):_____ Date: _____

Treatment Goals

Treatment Methods

Treatment plan review date: _____

Has a discharge date been established: ☐ Yes ☐ No
If Yes, describe necessary aftercare: _____

_____

_____

_____ _____ _____
Client's or Legal Representative's Signature *Client's or Legal Representative's Name (print)* *Date*

_____ _____ _____
Clinician's Signature *Clinician's Name (print)* *Date*