

# INITIAL DIAGNOSIS AND TREATMENT PLAN

Client name: \_\_\_\_\_

Date: \_\_\_\_\_

Plan for:  Individual therapy  Couple therapy  Family therapy  
Other participants (name and relationship): \_\_\_\_\_

### Planned treatment methods:

- Cognitive therapy
- Behavioral therapy
- Narrative therapy
- Solution-focused therapy
- Systemic therapy
- Supportive psychotherapy
- Play therapy
- Skill-building in the area of:
  - Communication
  - Relaxation
  - Social skills
  - Parenting
  - Anger management
- Trauma counseling
- Psycho-education
- Building insight
- Client empowerment
- Crisis management
- Homework/exercises

Diagnosis:

AXIS I \_\_\_\_\_

AXIS II \_\_\_\_\_

AXIS III \_\_\_\_\_

AXIS IV \_\_\_\_\_

AXIS V Intake GAF: \_\_\_\_\_ Highest past year: \_\_\_\_\_

Symptoms/justification for diagnosis: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Anticipated treatment frequency:  Weekly  Bi-weekly  Monthly

Other: \_\_\_\_\_

Anticipated duration of treatment: \_\_\_\_\_

Short-term goals/objectives: (target date < 3 months)

Target date:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Long-term goals/discharge criteria:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Client's strengths and assets: \_\_\_\_\_

Obstacles to treatment: \_\_\_\_\_

Developmental considerations/demands of the diagnosis (for child/adolescent): \_\_\_\_\_

Other treatments/services client is receiving: \_\_\_\_\_

Additional services recommended: \_\_\_\_\_

I understand and agree to the goals and services outlined in this treatment plan and I have been given the opportunity to give my input into developing this plan. We have discussed potential risks and benefits of the recommended treatments, as well as treatment alternatives.

Client signature: \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_

Clinician Signature \_\_\_\_\_ Date \_\_\_\_\_