Psychology Treatment Plan

CLIENT INFORMATION

Name: _____ Age: _____

Sex: _____ Date of birth: _____ dd / mm / yyyy

Phone number: _____ Date of consultation: _____ dd / mm / yyyy

Relevant patient history:

PRESENTING PROBLEM

Specify below:

ASSESSMENT AND DIAGNOSIS

Specify below:

TREATMENT GOALS

Short-term goals:

Long-term goals:

INTERVENTION/S

Specify below:

RECOMMENDED MEDICATION (IF APPLICABLE)

Specify below:

PROGRESS NOTES

Specify below:

HEALTHCARE PROVIDER'S INFORMATION

Name: _____ License ID/number: _____

Contact details: _____

Signature: