Substance Abuse Treatment Plan

Client name: _____ Date of birth: _____ dd / mm / yyyy

Gender: _____ Contact information: _____

Medical history:

PRESENTING PROBLEM

Primary substance(s) used:

Describe the problem:

Duration of problem:

Previous help sought:

TREATMENT GOALS

Long-term goals:

Short-term goals:

INTERVENTIONS

Describe the intervention, its implementation plan, and timeline.

Relapse prevention strategies:

Family therapy:

Behavioral therapy sessions:

Support groups:

COORDINATION OF CARE

Mental health professional involvement:

Additional resources:

FOLLOW-UP PLAN

Check-in frequency:

Progress monitoring:

HEALTHCARE PROFESSIONAL INFORMATION

Name: _____ License number: _____

Contact number: _____

Signature: