

# 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**

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Specify below:

**HEALTHCARE PROVIDER'S INFORMATION**

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Name:: \_\_\_\_\_ License ID/number:: \_\_\_\_\_

Contact details:: \_\_\_\_\_

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Signature: