

## INDIVIDUAL TREATMENT PLAN

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Health Plan Name: \_\_\_\_\_

Presenting Problem:

### I. DSM-IV (5 AXIS)

Axis I:

Axis II:

Axis III:

Axis IV: Psychosocial stressors:

Type(s) \_\_\_\_\_ Severity: \_\_\_\_\_

Axis V: Current GAF: \_\_\_\_\_ Highest GAF past year: \_\_\_\_\_

### II. PRESENT SYMPTOMS SUPPORTING DIAGNOSIS

### III. RELEVANT FAMILY AND SOCIAL HISTORY

IV. PREVIOUS MENTAL HEALTH SERVICES      Consulted:    Y/N    N/A

### V. CURRENT IMPAIRMENTS ATTRIBUTABLE TO DIAGNOSIS

### VI. SPIRITUAL HISTORY

**TREATMENT PROCEDURES**

**GOALS RELATIVE TO  
IMPAIRMENTS**

**OBJECTIVE  
CRITERIA FOR  
DISCHARGE**

**ANTICIPATED  
DATE OF GOAL  
ATTAINMENT**

**Medications: (names, dosage)**

**Prescribing  
Physician:** \_\_\_\_\_

**Consulted:    Y/N    N/A**

**MODALITIES:  
DURATION/FREQUENCY:**

Therapist \_\_\_\_\_ Date \_\_\_\_\_

Client \_\_\_\_\_ Date \_\_\_\_\_

Supervisor \_\_\_\_\_ Date \_\_\_\_\_

- |   |  |
|---|--|
| The client was informed in the following areas: |  |
| <input type="checkbox"/> 1.                     | Assessment of his/her condition                          |
| <input type="checkbox"/> 2.                     | Treatment Alternative                                    |
| <input type="checkbox"/> 3.                     | Possible outcomes and side effects                       |
| <input type="checkbox"/> 4.                     | Treatment recommendations                                |
| <input type="checkbox"/> 5.                     | Approx. length, cost & hope for outcome                  |
| <input type="checkbox"/> 6.                     | His/her rights/responsibilities in the treatment process |
| <input type="checkbox"/> 7.                     | Staff rights/responsibilities in the treatment process   |
| <input type="checkbox"/> 8.                     | Data Practices Act                                       |
| <input type="checkbox"/> 9.                     | Procedures for reporting grievances                      |
| <input type="checkbox"/> 10.                    | Name of therapist's supervisor                           |