Acentra HEALTH

# TREATMENT PLAN

**(This form is optional. You may use your own treatment plan form.)**

Please print legibly.

Client's Name _____ Age _____ Employer _____

Clinician's Name _____ Date _____

**DIAGNOSES:**

| **ICD 10#** | **Description** |
|---|---|
| | |
| | |
| | |
| | |

**TARGET PROBLEMS/SYMPTOMS:**

**SEVERITY OF SYMPTOMS:**

| | Mild | Moderate | Severe |
|---|---|---|---|
| 1._____ | ☐ | ☐ | ☐ |
| 2._____ | ☐ | ☐ | ☐ |
| 3._____ | ☐ | ☐ | ☐ |

Functional Impairment:_____

**TREATMENT OBJECTIVES:**

1._____

2._____

3._____

**SPECIFIC INTERVENTIONS:**

1._____

2._____

3._____

.

**Prognosis:** Excellent ☐ Good ☐ Fair ☐ Guarded ☐ Poor ☐

Projected Number of Visits_____ Projected Discharge Date_____

_____ _____

Counselor Signature Date