

Cognitive Behavioral Therapy (CBT) Treatment Plan

Patient information	
Name:	Age:
Sex:	Date of birth:
Phone number:	Date of treatment plan:
Diagnosis:	
Treatment goals	
Short-term goals	Long-term goals
Intervention/s	

Recommended medication (if applicable)

Progress notes

Client signature:

Date:

Mental health professional's information

Name:

Signature:

License number:

Contact details: