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: