

Individualized Treatment Plan

Patient information		
Name:		
Contact information:		
Sex:	Age:	
Date of birth:	Date of plan creation:	
Medical history		
General medical history:		
Behavioral health history:		
Diagnostic assessment summary		
Intensity of needs determination: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Condition classification: <input type="checkbox"/> Severe emotional disturbance (SED) <input type="checkbox"/> Serious mental illness (SMI) <input type="checkbox"/> Other:	
Primary diagnoses (ICD-10 codes):		
Date of diagnostic assessment:		
Name and credentials of the professional who conducted the assessment:		
Current functional assessment		
1. Behavioral and psychological status		
Emotional state:	Normal	Abnormal
Cognitive functioning:	Normal	Abnormal
Social functioning:	Normal	Abnormal

2. Physical health status

- Normal
- Minor issues
- Significant issues

Treatment strategies

Treatment approach (e.g., CBT, Play Therapy):

Specific interventions:

Cultural or personal considerations:

Goals and objectives

Goals 1:

Objective 1:

Goals 2:

Objective 2:

Goals 3:

Objective 3:

Prescribed services**Service #1:**

Scope:

Duration:

Provider:

Therapeutic goal:

Service #2:

Scope:

Duration:

Provider:

Therapeutic goal:

Service #3:

Scope:

Duration:

Provider:

Therapeutic goal:

Service #4:

Scope:

Duration:

Provider:

Therapeutic goal:

Schedule for accomplishing goals**Timeline for goal 1:****Timeline for goal 2:****Timeline for goal 3:****Re-evaluation date:****Coordination of care****Collaborating providers and roles:****Care coordination plan:****Discharge plan****Planned duration of services:****Criteria for discharge:****Aftercare recommendations:****Aftercare providers or organization:**

Progress notes

Progress towards goals:

Temporary services (if applicable):

Healthcare professional information

Name:

License ID number:

Signature:

Date of plan creation: