

Substance Abuse Treatment Plan

Client name:	Date:
Gender:	Date of birth:
Contact information:	
Medical history:	
Presenting problem	
Primary substance(s) used:	
Describe the problem:	
Duration of the problem:	
Previous help sought:	
Treatment goals	
Long-term goals:	
Short-term goals:	

Interventions *(Describe the intervention, its implementation plan, and timeline.)*

Relapse prevention strategies:

Family therapy:

Behavioral therapy sessions:

Support groups:

Coordination of care

Mental health professional involvement:

Additional resources:

Follow up plan

Check-in frequency:

Progress monitoring:

(Document the data collection plan, frequency, analysis methods, and treatment plan adjustments.)

Healthcare professional information

Name:

Signature:

License number:

Contact number: