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INITIAL TREATMENT PLAN

PATIENT NAME: ______________________________

PATIENT ID #: ______________________________

DATE OF BIRTH: ______________________________

DIAGNOSTIC INFORMATION

DSM IV

AXIS I: ______________________________

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AXIS II: ______________________________

AXIS III: ______________________________

AXIS IV: GAF SCORE ______________________________

Long term Goals/Criteria for Discharge: ____

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Area of Patient Strengths/Area of Concern: ____

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The treatment plan has been reviewed with the patient and the patient understands the goals of his/her treatment.

Practitioner Signature:____Date:____________________

<u>OPTIONAL:</u>

I have read and understand the treatment plan and agree with the contents.

Practitioner Signature:____Date:____________________