Psychology Treatment Plan

Client information	
Name:	**Age:**
Sex:	**Date of birth:**
Phone number:	**Date of consultation:**
Relevant patient history:	
Presenting problem	
Assessment and diagnosis	
Treatment goals	
Short-term goals	**Long-term goals**

Intervention/s
Recommended medication (if applicable)
Progress notes

Healthcare provider’s information	
Name:	**License ID/number:**
Contact details:	**Signature:**