

Treatment Information

Requested Treatment Start Date: _____ **Date of initial session:** _____

Expected Treatment (TX) Outcome: _____ problem resolution _____ symptom reduction _____ maintenance

TX modalities requested by you: _____ individual _____ family _____ group _____ medication management

Frequency of TX requested: Weekly _____ Bi-Weekly _____

Estimated Sessions to TX completion: _____

Please document the following:

Treatment Plan:

Progress:

Barriers for treatment goals: