

TREATMENT PLAN - AODA SERVICES

CLIENT NAME: _____

DATE: _____

DIAGNOSIS: _____

THERAPIST: _____

STATEMENT OF PROBLEM #1:

SHORT-TERM GOAL/OBJECTIVE:

ACTION PLAN/SERVICE:

FREQUENCY:

LONG-TERM GOAL:

STATEMENT OF PROBLEM #2

SHORT-TERM GOAL/OBJECTIVE:

ACTION PLAN/SERVICE:

FREQUENCY:

LONG-TERM GOAL:

STATEMENT OF PROBLEM #3

SHORT-TERM GOAL/OBJECTIVE:

ACTION PLAN/SERVICE:

FREQUENCY:

LONG-TERM GOAL:

CRITERIA FOR DISCHARGE:

CLIENT SIGNATURE: _____ DATE: _____

COUNSELOR SIGNATURE: _____ DATE: _____

SUPERVISOR SIGNATURE: _____ DATE: _____

M.D. SIGNATURE: _____ DATE: _____