

# 30/90 DAY CLIENT REVIEW AODA

CLIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PRIMARY THERAPIST: \_\_\_\_\_

SUPERVISING PSYCHOLOGIST: \_\_\_\_\_

DATE INITIAL TRM'T. PLAN SIGNED BY SUPERVISOR: \_\_\_\_\_

STAFF PRESENT: \_\_\_\_\_

ACTIVITY/PROGRESS:

CONCERNS:

CURRENT TREATMENT PLAN, INCLUDING TREATMENT STRATEGIES, GOALS AND  
EXPECTED OUTCOMES:

CURRENT DIAGNOSIS:

CLIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

THERAPIST SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SUPERVISING PSYCHOLOGIST: \_\_\_\_\_ DATE: \_\_\_\_\_

M.D.SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_