

Outpatient Treatment Plan and Goal Sheet

Patient & Provider Information

Patient Full Name:

Date of Birth:

Record/Case Number:

Admission/Start Date:

Primary Clinician/Therapist:

Clinical Overview

Primary Diagnosis / Presenting Problems:

Secondary Diagnosis (if applicable):

Treatment Modalities (e.g., CBT, Individual Therapy):

Treatment Goals and Objectives

Identify specific, measurable goals and the steps required to achieve them.

Goal 1

Primary Goal Description:

Measurable Objective 1:

Measurable Objective 2:

Clinician Intervention/Support:

Target Completion Date:

Goal 2

Primary Goal Description:

Measurable Objective 1:

Measurable Objective 2:

Clinician Intervention/Support:

Target Completion Date:

Goal 3

Primary Goal Description:

Measurable Objective 1:

Measurable Objective 2:

Clinician Intervention/Support:

Target Completion Date:

Service Delivery & Frequency

Session Frequency (e.g., Once per week):

Estimated Duration of Treatment (e.g., 12 weeks):

Review/Re-evaluation Date:

Signatures and Agreement

By signing below, the clinician and patient agree to the outlined goals and treatment plan.

Patient Printed Name:

Patient Signature (For Print):

Date:

Clinician Printed Name / Credentials:

Clinician Signature (For Print):

Date: