**U.S Probation Office – Western District of North Carolina**

**Mental Health Treatment Plan**

Client Name: Enter Client Name Treatment Plan Type: [ ]  Initial

Treatment Provider: Enter Program Name [ ]  90-day Revision

Admission Date: Enter Date Treatment Plan Date: Enter Date

DSM Diagnosis: List Diagnoses

Current Medication(s): List Medication(s)

Short Term Goals/Objectives – Target Date:

|  |  |
| --- | --- |
| Goal #1 | Enter Goal #1* Enter Objective #1
* Enter Objective #2
* Enter Objective #3
 |
| Goal #2 | Enter Goal #2* Enter Objective #1
* Enter Objective #2
* Enter Objective #3
 |
| Goal #3 | Enter Goal #3* Enter Objective
* Enter Objective
* Enter Objective
 |

Long Term Goals/Objectives – Target Date:

|  |  |
| --- | --- |
| Goal #1 | Enter Goal #1* Enter Objective #1
* Enter Objective #2
* Enter Objective #3
 |
| Goal #2 | Enter Goal #2* Enter Objective #1
* Enter Objective #2
* Enter Objective #3
 |
| Goal #3 | Enter Goal #3* Enter Objective
* Enter Objective
* Enter Objective
 |

Identified Client Strengths/Abilities:

|  |  |
| --- | --- |
| Strength #1 | Enter Strength #1  |
| Strength #2 | Enter Strength #2 |
| Strength #3 | Enter Strength #3 |

Frequency of Services: Enter Frequency of Services

Specific Criteria for Program Completion: Enter Criteria

Information on Family/Significant Others: Enter Information

Continued Need for Treatment (Check One): [ ] Yes [ ] No

Additional Comments: Enter Comments

 Type Clinician Name for Signature Enter Date

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Clinician Signature Date