

Counseling Plan

CLIENT NAME: _____

CASE # _____

SESSION DATE: _____

ATTENDEES: _____

TARGET PROBLEM(s)*:

SPECIFIC COUNSELING GOAL(s)*

SPECIFIC STRATEGIES AND INTERVENTIONS: *(Define in specific behavioral terms and time frames, include homework assignments and treatment coordination)**

TREATMENT COORDINATION: *(Check all appropriate boxes when coordination is needed to meet goals, then note when the meeting occurred and what transpired. * Use additional blank pages if more notes are needed.)*

1. Communicate with Primary Care Physician? _____
2. Communicate with other treatment providers? _____
3. Request records from previous counseling? _____
4. Communicate with client's school or other agencies? _____
5. Involve family members in treatment? _____
6. Case consultation with EAP Consultant? _____

Case consultation notes: _____

My signature indicates I have participated in the development of this counseling plan and agree with the recommended goals and interventions.

I would like a copy of my Counseling Plan: YES NO

Client Signature _____

Date _____

Clinician Signature

Credentials

Date