Treatment plan step-by-step sheet

Free template from soapnotes.xyz. Fill it in by hand or type over it.

STEP 1: GATHER

Client

Date:

Sources used (intake, assessment, scores, records, client interview):

Reason for care, in the client's words:

STEP 2: SUMMARISE THE PICTURE

Main problems, in order of priority:

Strengths and supports (people, skills, routines that help):

Barriers (practical, health, money, time, other):

Diagnosis or clinical impression, if your role and setting call for one:

Scores at baseline (name of scale, score, date):

STEP 3: SET GOALS WITH THE CLIENT

Goal 1, in the client's words:

Goal 1, written so it can be checked (what, how much, by when):

Goal 2, if needed:

STEP 4: BREAK GOALS INTO OBJECTIVES

Objective 1.1

Objective 1.2

How progress will be measured (scale, log, count, observation):

STEP 5: SAY WHAT YOU WILL DO

Type and length of sessions, and how often:

Specific interventions and which objective each supports:

Referrals, coordination and who is responsible:

Medication review, if relevant

STEP 6: SAFETY AND CRISIS

Asked about thoughts of self-harm, and the answer:

Safety steps, supports and contacts agreed:

What would trigger an earlier review:

STEP 7: AGREE AND SIGN

Plan discussed with the client? Client's comments:

Client agrees? [yes, partly, no, with what changes

Who else received a copy (as the client agreed and rules allow):

Review date:

Signatures and dates (clinician, client, others your setting requires):

STEP 8: REVIEW

Progress against each objective (with measures and dates):

What changes, and why:

Next review date:

Educational template, not medical or legal advice. Follow your employer and regulator rules.