Alternative Interventions INITIAL TREATMENT PLAN

CLIENT	
NAME:	
DOB:	**AGE:**
SSN #:	

BRIEFLY DESCRIBE REASON FOR REFERRAL or VISIT

(e.g. infidelity, Frequent arguments, difficulty resolving problems, frequent misunderstandings, poor communication, or boundary violations)

BRIEFLY DESCRIBE PROBLEM/SYMPTONS

(e.g. not speaking, sleeplessness, yelling, slapping, or hitting, increased depression, anxiety, stress, or sadness)

BRIEFLY DESCRIBE YOUR DESIRED GOALS

(e.g. Enhance trust, develop a loving marriage or partnership, develop positive communication style)

CLIENT(s) /GUARDIAN SIGNATURES:	DATE:
CLINICIAN SIGNATURE:	DATE:

By signing this document you agree to allow this initial treatment plan agreement to serve as authorization for your initial treatment plan and verbal permission for the development of a modified master treatment plan based on assessment outcomes and ongoing issues presented during the course of your treatment while utilizing a telehealth platform.

2006 Modified 2020