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## Treatment Plan

Client Name:

Date

Problems/Symptoms:

Long Term Goal:

Short Term Goal(s):

Objectives:

Interventions:

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Leslie F Small, MS LPC NCC

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse/Significant Other Signature    Date