# **60 DAY MASTER TREATMENT PLAN**

Client Name:

Age:

Client ID:

Date of Birth:

## DSM-V DIAGNOSIS:

Current GAF: Highest GAF Past Year:

Needs/Concerns:

Treatment Goal #1:

Interventions:

Criteria for Completion:

Treatment Modality:

Individual Therapy (Frequency: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_)

Family Therapy with Patient (Frequency: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_)

Family Therapy- Patient Not Present (Frequency: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_)

Group Therapy (Frequency: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_)

Other