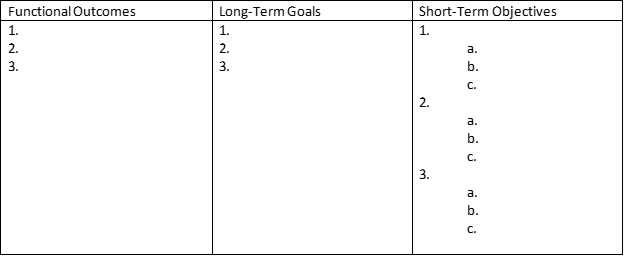


### **Clinical Treatment Plan**

Client: File #:

DOB: Dates of Services:

Student Clinician: Supervisor:



**Client’s Current Level of Functioning:**

**Goals:**

**Treatment Approaches:**

**Treatment Rationale:**

**Caregiver Plan:**

**Signatures:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client/ Caregiver

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Student Clinician

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Clinical Supervisor Date