Client ID #:	Client Name:	
Initial Tx Plan Date: 5/1/16	Current Treatment Plan: 5/1/16	Expiration Date: 5/2/16

DSM Diagnosis: Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text. **Narrative** Click here to enter text. Mild **ICD 10 Diagnosis:** Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text.

Type of Service

☒ Individual 1 X Wk	☒ Group 1 X Wk	☒ Comm Supp Grp 3 X Wk	☐ UA/Breathalyzer Wk

Dimensions

1. Acute Intox/Withdraw Potential **3. Emot/Behavioral. Cognitive Condit/Complications** **5. Relapse/Continued Use/Continued Problem Potential**
2. Biomed Conditions/Complications **4. Readiness to Change** **6. Recovery Environment**

Date	Dim	Severity 0-1-2-3-4	Prob #	Problem Statement	Goal	S or L Term	Action Steps	T or C Date
5/1/16	1 Choose an item.	0	1	Click here to enter text.	Click here to enter text	L	1. 2. 3. 4.	5/1/16
5/2/16	1 *Preparation*	0	1	Click here to enter text.	Click here to enter text	L	1. 2. 3. 4.	5/1/16
5/1/16	1 Choose an item.	0	1	Click here to enter text.	Click here to enter text	L	1. 2. 3. 4.	5/1/16

Legend: S = Short-Term vs L = Long-Term; T = Target Date; C = Complete

This client is appropriate for substance abuse treatment meeting medical necessity of the diagnosis. I agree with the goals of treatment.

Primary Counselor Printed Name, Credentials & # / Signature	5/1/16 DATE	ClinSup Printed Name, Credentials & # / Signature	5/1/16 DATE
Client Printed Name / Signature	5/1/16 DATE	LPHA Printed Name, license & # / Signature	5/1/16 DATE

☐ I have received a copy ☐ **I do not want a copy**

Commented [LS1]: