The Treatment Planning Toolkit

From Clinical Assessment to Meaningful Goals | A guide + fillable template

A treatment plan is a working agreement about what matters, why the work may help, and how therapist and client will recognize meaningful change. Use this sequence as a clinical reasoning aid, not a universal protocol.

A six-part path from story to plan

1 ASSESS

Explore presenting concerns, safety, relevant history, strengths, culture, symptoms, functioning, preferences, and contextual barriers.

2 FORMULATE

Develop a tentative, revisable explanation of what contributes to and maintains the difficulty. Differentiate hypotheses from established findings.

3 COLLABORATE

Ask what the client hopes will be different in everyday life. Identify priorities in the client's language.

4 WRITE THE GOAL

Describe a meaningful direction of change connected to the presenting concern, functional needs, and client priorities.

5 SPECIFY OBJECTIVES + INTERVENTIONS

Identify observable or reportable indicators, baseline, review interval, and interventions appropriate to the client and clinician's competence.

6 REVIEW + REVISE

Use client feedback, functioning, clinical observations, and appropriate measures to evaluate fit, progress, risk, and ongoing need.

KEEP THE PLAN ALIVE

Goals are collaborative and revisable. A numerical target is useful only when meaningful to the client and clinically justified; a score alone does not define success.

A Worked Example: Morgan

Fictional illustration | From client language to clinical reasoning

Morgan reports persistent worry, sleep difficulty, and a tendency to accept requests immediately, followed by resentment and exhaustion. The examples below illustrate a planning process, not a diagnosis or a complete assessment.

CLIENT'S WORDS

“I keep saying yes, even when I don't have the capacity. I want to stop feeling responsible for everyone's reactions.”

ASSESSMENT + FUNCTION

Explore symptom course, differential diagnosis, risk, sleep, relationship and work functioning, context, strengths, and preferred treatment approach.

WORKING FORMULATION

Anticipated rejection evokes anxiety and bodily tension; rapid agreement provides short-term relief but contributes to overcommitment and relational strain. This is a hypothesis to test collaboratively.

COLLABORATIVE GOAL

Increase flexibility in communicating needs and reduce anxiety-driven interpersonal avoidance, with improvement in day-to-day functioning.

INDIVIDUALIZED OBJECTIVE

Recognize early anxiety cues and practice pausing before responding to requests. Compare baseline situations with later examples of decision-making, distress, and functioning.

INTERVENTIONS

As appropriate: ACT-informed defusion and values work, attachment exploration, somatic noticing, and behavioral rehearsal. Match choices to assessment, preference, and competence.

REVIEW

At agreed intervals, ask what has changed in real interactions, what remains difficult, whether goals still fit, and whether clinical needs or safety concerns warrant a change.

EXAMPLE OF PROGRESS, NOT A MAGIC NUMBER

Morgan notices chest tension before agreeing, pauses on several occasions, and reports less interference with work decisions even while some anxiety remains.

Fillable Treatment Plan: Foundation

Complete collaboratively and store only in an approved, secure clinical record system

Client identifier / record reference (avoid unnecessary identifying details)

Plan date, clinician, and planned review date

Presenting concerns and client priorities (client's words)

Assessment summary: symptoms, functioning, context, strengths, relevant risks

Working formulation and diagnostic considerations (note uncertainty)

Client preferences, accessibility needs, cultural / contextual considerations

Use only with appropriate privacy safeguards. This PDF is not an electronic health record.

Fillable Treatment Plan: Goals

Duplicate this page when additional goals are needed

Client-identified desired change

Collaborative treatment goal

Measurable objective(s): observable / reportable indicators and baseline

Planned interventions and clinical rationale

How progress will be assessed (tools, interviews, functioning, feedback)

Review interval / frequency and client participation in planning

Fillable Review + Revision

Progress is more than a symptom score; treatment planning remains collaborative

Date of review and current treatment focus

What has changed? Client report, functioning, observations, measures

What remains difficult? Barriers, safety, alliance, treatment fit

Clinical decision: continue, adapt, revise, consult, refer, or plan ending

Updated goal(s), intervention(s), next review, or continuity plan

PRACTICE NOTE

Document according to current law, professional standards, organizational policies, and payer requirements. Reassess risk as indicated; use tools according to their instructions and permissions. This educational template does not replace a full assessment, required treatment-plan elements, supervision, or an approved EHR.