Universal Psychotherapy Treatment Plan

Client-centered | diagnosis-neutral | payer-aware | fillable

Client identifier, clinician, credentials, plan date

Service type, setting, frequency, estimated duration, next review

Specify clinical rationale for frequency and anticipated review interval.

Chief complaint and client-stated priorities

Use the client's own language where possible; include their desired changes.

Presenting symptoms: course, severity, duration, and context

Identify individualized symptoms consistent with documented assessment findings.

Functional impact and relevant life domains

Describe specific effects on relationships, work/school, self-care, sleep, or daily living.

Assessment and Clinical Rationale

Link diagnostic reasoning, lived experience, and necessity of care

Diagnosis and ICD-10-CM code(s); status of assessment

Include supported diagnosis or document assessment status and follow payer rules.

Diagnostic evidence and differential considerations

Describe supporting symptoms, clinically significant distress/impairment, and uncertainties.

Relevant history, strengths, identity/context, supports, and preferences

Clinical formulation: patterns, maintaining factors, protective factors

Medical necessity and rationale for treatment

Explain why the chosen service, frequency, and level of care are clinically indicated.

Safety/risk considerations and related plan, if indicated

Reference separate assessment or safety plan as appropriate.

Goal 1 | Symptom Reduction

Reduce presenting symptoms or related distress in ways meaningful to the client

SMART here means specific, meaningful, achievable, relevant, and time-bound. Measurement may be qualitative, functional, observational, or client-reported; arbitrary numerical quotas are not required.

Collaborative goal statement

Starting point / baseline and meaningful indicators of change

Describe how the client and therapist will recognize movement, without requiring a numerical score.

Objective 1 | specific, observable or reportable, and time-framed

Objective 2 | specific, observable or reportable, and time-framed

Objective 3 | specific, observable or reportable, and time-framed

Interventions / modalities and clinical rationale

Specify evidence-informed interventions tailored to client preferences, formulation, and clinician competence.

How progress will be assessed; anticipated review date

Goal 2 | Increased Functioning

Improve participation, capacity, and functioning in affected life domains

SMART here means specific, meaningful, achievable, relevant, and time-bound. Measurement may be qualitative, functional, observational, or client-reported; arbitrary numerical quotas are not required.

Collaborative goal statement

Starting point / baseline and meaningful indicators of change

Describe how the client and therapist will recognize movement, without requiring a numerical score.

Objective 1 | specific, observable or reportable, and time-framed

Objective 2 | specific, observable or reportable, and time-framed

Objective 3 | specific, observable or reportable, and time-framed

Interventions / modalities and clinical rationale

Specify evidence-informed interventions tailored to client preferences, formulation, and clinician competence.

How progress will be assessed; anticipated review date

Goal 3 | Individualized Priority

A collaborative goal reflecting why this person came to therapy

SMART here means specific, meaningful, achievable, relevant, and time-bound. Measurement may be qualitative, functional, observational, or client-reported; arbitrary numerical quotas are not required.

Collaborative goal statement

Starting point / baseline and meaningful indicators of change

Describe how the client and therapist will recognize movement, without requiring a numerical score.

Objective 1 | specific, observable or reportable, and time-framed

Objective 2 | specific, observable or reportable, and time-framed

Objective 3 | specific, observable or reportable, and time-framed

Interventions / modalities and clinical rationale

Specify evidence-informed interventions tailored to client preferences, formulation, and clinician competence.

How progress will be assessed; anticipated review date

Monitoring and Treatment Review

Track progress collaboratively and revise treatment as needs evolve

Consider client report, clinical interview, functional assessment, observation, standardized or individualized measures, clinician-rated measures, and follow-up. Use methods relevant to the presentation.

Selected monitoring methods and why they fit this client

Progress across Goals 1, 2, and 3

Note client-defined change, symptoms, functioning, engagement, and relevant barriers.

Plan review: client feedback, adjustments, continued need

Record rationale for continuing, revising, stepping down, or concluding services.

Next review date and updated frequency / treatment duration

Collaboration, Documentation, and Use

Treatment plans are living clinical documents, not scripts

Client collaboration, preferences, agreement, and date

Document participation and agreement; note differing views or declined elements accurately.

Clinician signature / credentials / date; client signature if required

Verify signature and attestation requirements for your practice and payer.

Additional clinically relevant information or revisions

DOCUMENTATION REMINDERS

- Progress notes should document the care actually delivered, client response, and clinical rationale; avoid copying plan language as a substitute for session-specific evidence.
- Use individualized DSM-5-TR-consistent diagnostic findings when applicable. A diagnosis alone does not establish medical necessity or guarantee coverage.
- Review progress routinely and conduct a fuller plan review when clinically indicated or required by payer or practice policy. A 90-day review may be a useful default, not a universal rule.
- Verify each commercial plan's requirements for covered diagnoses, measurable objectives, signatures, authorizations, review frequency, and records. This template does not guarantee reimbursement.
- Store completed documents containing protected health information only in an appropriately secure clinical record system.

Completed Fictional Example: Morgan

Illustrative only. Not a real client, validated protocol, or substitute for individualized assessment, supervision, or payer review. The example uses qualitative and functional indicators rather than arbitrary numerical targets.

Client and treatment information

Morgan (fictional adult); treating clinician: Example Therapist, LMFT. Plan initiated November 2026. Individual outpatient psychotherapy, initially weekly, with frequency reassessed according to clinical need and response. Initial comprehensive review anticipated in approximately 90 days, or sooner if clinically indicated.

Chief complaint and presenting concerns

Morgan seeks therapy because persistent worry, anticipatory tension, and fear of disappointing others have made ordinary decisions and relationships exhausting. Morgan hopes to feel less consumed by worry, participate more freely in daily life, and communicate needs without immediately retracting them.

Symptoms, duration, and functional impact

Morgan reports excessive worry across work, relationships, and routine responsibilities over more than six months, difficulty controlling worry, restlessness, muscle tension, impaired concentration, irritability, and disrupted sleep. Worry contributes to delayed decisions, avoidance of difficult conversations, overcommitting, and reduced rest. These patterns cause clinically significant distress and interfere with work and relationships.

Diagnosis and clinical rationale

Working diagnosis: Generalized Anxiety Disorder, F41.1, based on reported pervasive worry, difficulty controlling worry, associated symptoms, duration, distress, and impairment. Continue assessment for other contributors, including mood symptoms, trauma-related responses, medical conditions, substance effects, and contextual stressors. The diagnosis is illustrative, not established through a real clinical evaluation.

Formulation and medical necessity

Morgan anticipates rejection when setting limits, attempts to prevent conflict through reassurance-seeking and overfunctioning, and experiences short-term relief when avoiding direct requests. Avoidance may reinforce worry and exhaustion. Strengths include insight, willingness to reflect, valued relationships, and motivation for change. Outpatient psychotherapy is indicated to address persistent symptoms and functional impairment through individualized interventions, with ongoing evaluation of treatment intensity and appropriateness.

Goal 1 | Symptom reduction

Goal: Morgan will experience less disruptive worry and related physical tension, with increased ability to respond flexibly when anxiety arises.
Objective 1: Over the initial treatment phase, Morgan will recognize common worry cues and describe patterns that intensify distress during session check-ins.
Objective 2: Morgan will practice a personally acceptable grounding, acceptance, or regulation strategy when worry becomes intrusive and reflect on its usefulness in sessions.
Objective 3: Morgan will increasingly distinguish solvable concerns from repetitive worry and practice responding without prolonged reassurance-seeking, as reflected in client examples.
Interventions: ACT-informed defusion and acceptance, collaborative psychoeducation, somatic awareness, and tailored coping experiments. **Progress indicators:** Morgan reports less time dominated by worry and more capacity to redirect attention toward chosen activities.

Goal 2 | Increased functioning

Goal: Morgan will participate more consistently in valued daily activities and relationships despite the presence of some anxiety.
Objective 1: Morgan will identify activities or responsibilities most affected by worry and collaboratively choose manageable opportunities to re-engage.
Objective 2: Morgan will experiment with setting realistic limits on work or relational commitments and discuss resulting changes in energy and functioning.
Objective 3: Morgan will develop and adjust a sustainable evening transition routine that supports rest and readiness for daily responsibilities.
Interventions: Values clarification, behavioral activation or graded engagement, collaborative problem-solving, and practical boundary rehearsal. **Progress indicators:** Client-described improvement in follow-through, restorative time, and ability to participate in important roles.

Goal 3 | Individualized priority

Goal: Morgan will express personal needs and preferences more openly in important relationships while remaining connected to personal values.
Objective 1: Morgan will explore beliefs and relational experiences that make asking for support or disagreeing feel unsafe.
Objective 2: Morgan will practice language for communicating needs and boundaries in sessions and identify an authentic approach that feels workable.
Objective 3: Morgan will reflect on real-world attempts to communicate needs, including emotional responses, relationship dynamics, and what they would like to try differently.
Interventions: Attachment-informed exploration, experiential or parts-informed reflection when appropriate, and communication rehearsal. **Progress indicators:** Morgan describes increased choice and authenticity in conversations rather than relying solely on others' approval.

Monitoring and treatment review

Monitor through collaborative session check-ins, Morgan's descriptions of worry and functioning, clinician observation, and an appropriate symptom measure if clinically useful. Compare changes with the initial baseline and client-defined priorities. At review, assess progress toward each objective, barriers, evolving preferences, ongoing medical necessity, and whether frequency or interventions should change. A plateau would prompt reassessment, not automatic continuation of the same plan.

Client collaboration and documentation

Morgan participated in identifying the goals and expressed a preference for practical experiments alongside reflective exploration. Example documentation: "Client verbally agreed to the collaboratively developed goals and proposed interventions; plan will be reviewed together and adjusted as indicated." Actual clinicians should document the agreement and any signatures according to applicable requirements. Session notes must separately reflect the services delivered and the client's response.