The Columbus Wellness Center
124 Hyatts Rd Delaware, OH 43015

# Psychotherapy Treatment Plan

Clinician: ____________________________ Date: _________ Time: _________

Patient: _____________________________ Payer: ________________________

Primary Diagnoses: _________________________________ ICD 10: _____________
Secondary Diagnoses: ________________________________ ICD 10: _____________
Tertiary Diagnoses: __________________________________ ICD 10: _____________

**Presenting Problem** (in the clients own words):

_________________________________________________________________________________________________
_________________________________________________________

**Treatment Goal:**

Estimated Time to Complete: ____________ Days Months Years

**Objective:**

**Strategy/ Intervention:**

Estimated Time to Complete: ____________ Days Months Years

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**Presenting Problem** (in the clients own words):

_________________________________________________________________________________________________
_________________________________________________________

**Treatment Goal:**

Estimated Time to Complete: ____________ Days Months Years

**Objective:**

**Strategy/ Intervention:**

Estimated Time to Complete: ____________ Days Months Years

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**Presenting Problem** (in the clients own words):
____________________________________________________________________________________________
______________________________________________________

**Treatment Goal:**

Estimated Time to Complete: ____________ Days Months Years

**Objective:**

**Strategy/ Intervention:**
Estimated Time to Complete: ____________ Days Months Years

**Presenting Problem** (in the clients own words):
____________________________________________________________________________________________
______________________________________________________

**Treatment Goal:**

Estimated Time to Complete: ____________ Days Months Years

**Objective:**

**Strategy/ Intervention:**
Estimated Time to Complete: ____________ Days Months Years

**Prescribed Frequency of Treatment:** (#) _______ Weekly Monthly Yearly

☐ I declare that these services are medically necessary and appropriate to the recipient's diagnosis and needs.

**Clinician Name:** ________________________________

**Clinician Signature:** _________________________________

License #: ________________________

I declare this information to be accurate and complete.

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