

INDIVIDUAL SERVICE PLAN

(Page 1)

rev. 04/24/06

Client Name: _____ ID#: _____ Date Initiated: _____

Sources of Information:

Diagnosis: Axis I
 Axis II
 Axis III
 Axis IV Psychosocial Stressors--
 Axis V Initial GAF--

Strengths-
 Needs-
 Abilities-
 Preferences-

Client needs as presented by client:

Problem #	Goal Initiation Date	Goal: What is the client working on changing in treatment?	Objective: Observable/measurable evidence of this change?	Resource/ Responsible Staff	Service Type	Frequency of Contact	Solution Target Date	Progress/ Date

See Page 3 for Resource Key/Service Type Key

Check here if goals are continued on another page

Progress: A=Attained, R=Revised, C=Canceled

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Client Name: _____ ID#: _____ Date Initiated: _____

Client response to the treatment plan:

All persons signing below have participated in making this treatment plan and agree to follow it.

Client Signature: _____

Date: _____

Client Refused to Sign

(Staff Initial)

(Date)

SERVICE TYPE KEY:

DA = Diagnostic Assessment Services

C = Psychotherapy/Counseling Services

M = Medication/Somatic Services

(IT) Individual Therapist: Signature _____

Print Name _____

Title/Credentials _____

(CS) Clinical Supervisor (s): Signature _____

Print Name _____

Title/Credentials _____

(G) Group Leader: Signature _____

Print Name _____

Title/Credentials _____

(P) Psychiatrist: Signature _____

Print Name _____

Title/Credentials Psychiatrist

(O) Other: 1. Agency _____

Name/title of Contact _____

Service provided _____

How coordinate service _____

**INDIVIDUAL SERVICE PLAN
REVIEW**

(Page)

Client Name: _____ ID#: _____

Date ISP Initiated: _____ Current GAF: _____ Date ISP Reviewed: _____

Narrative description of progress in treatment to date:

Comments concerning modifications to initial treatment plan:

I agree to the above comments and I agree to the revisions to this ISP.

Client Signature: _____

Date: _____

Client Refused to Sign

Individual Therapist: Signature _____

Print Name _____

Title/Credentials _____

Clinical Supervisor (s): Signature _____

Print Name _____

Title/Credentials _____

Group Leader: Signature _____

Print Name _____

Title/Credentials _____

Psychiatrist: Signature _____

Print Name _____

Title/Credentials Psychiatrist