

**MID-OHIO PSYCHOLOGICAL SERVICES, INC.
PLAN-OF-ACTION**

Client Name and ID: _____ **Preparation Date:** _____

Test/Assessment Tools Used:

Provisional Diagnosis:

Axis I:
Axis II:
Axis III:
Axis IV: Psychosocial Stressors
Axis V: Current GAF:

Specific Treatment Issues (client strengths and needs):

Strengths:

Needs:

Tentative Treatment Goals:

Current Plan of Action:

	Signature:	Name(print):	Title:	Date:
Client/Guardian			Self/Guardian	
Counselor				
Clinical Supervisor				