

TREATMENT PLAN

Client Name: _____

Choose One: Original plan Reassessment date _____

Short-term client goals:

Long-term client goals:

Therapist Objectives:

1) Frequency, 2) length, and 3) duration of visits:
1) _____ 2) _____ 3) _____

Progress "measurements" to be used: (Ex.— pain scale, range of motion, increased ability to perform function)

Dates of reassessment:

Categories of massage methods to be used: (Ex.— relaxation, stress reduction, lymphatic, neuromuscular, connective tissue, neurochemical, etc.)

Additional notes:

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Treatment Plan Form.