

TREATMENT PLAN

Client Name: _____

Choose One: Original plan Reassessment date _____

Short-term client goals:

Quantitative: _____

Qualitative: _____

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.— general constitutional, stress reduction, circulatory, lymphatic, neuromuscular, connective tissue, neurochemical, etc.)

Additional notes:

Client Signature: _____

Date: _____

Therapist Signature: _____

Date: _____