Child and Adolescent Mental Health Care Plan

Client Details

Name:

Full name

Date of Birth:

Gender:

Gender

Address:

Address

Parent/Guardian Name:

Parent/Guardian Name

Contact Number:

Contact Number

Presenting Issue(s)

Describe the main concerns or issues

Relevant History

Include developmental, family, school, medical, and previous interventions

Assessment (Summary/Diagnosis)

Summary of findings and preliminary diagnosis

Goals

Goal	Intervention/Strategy	Timeline
Goal 1	Intervention	Timeline

Goal 2	Intervention	Timeline

Plan

Summary of planned steps, referrals, monitoring

Review

Date	Progress Notes	Next Steps
	Notes	Actions

Clinician Name:

Clinician Name

Date Prepared:

Signature:

Signature