Eating Disorder Therapeutic Care Plan Sample

Client Name: _____

Date of Birth: _____

Date of Plan: _____

Therapist: _____

Diagnosis

Presenting Problem

Goals

Short-Term Goals

- _____
- _____

Long-Term Goals

- _____

Objectives

- _____
- _____

Interventions

- _____
- _____

Client Strengths

Expected Outcomes

Review Date: _____

Therapist Signature: _____