

## TREATMENT DIRECTION

What will be the focus of therapy?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Assertiveness/Boundaries       | <input type="checkbox"/> Problem Solving Skills Training | <input type="checkbox"/> Anger Management    |
| <input type="checkbox"/> Solution Focused Techniques    | <input type="checkbox"/> Emotional Expression            | <input type="checkbox"/> Stress Management   |
| <input type="checkbox"/> Restructuring Thought Patterns | <input type="checkbox"/> Relationships                   | <input type="checkbox"/> Communication       |
| <input type="checkbox"/> Boundaries                     | <input type="checkbox"/> Loss/Grief                      | <input type="checkbox"/> Decision Making     |
| <input type="checkbox"/> Stress Management              | <input type="checkbox"/> Pattern Id/Restructuring        | <input type="checkbox"/> Parent/Co-Parenting |
| <input type="checkbox"/> Work Related Stress            | <input type="checkbox"/> Work/Life Balance               | <input type="checkbox"/> Mediation           |

Other:

\_\_\_\_\_

What interventions or techniques would you like to learn?

- ☐ Speaking Up for Self/Setting Boundaries with family, Friends and Others/Work
- ☐ Decision Making Models
- ☐ Managing Anger and/or Stress with appropriate emotional expression
- ☐ Communication skills to increase the quality of relationships
- ☐ Understand the Loss and Grief Process and ways to express/heal from loss
- ☐ Relationship skills to increase the relationship such as communication, conflict resolution
- ☐ Parenting skills to unite parents and reduce conflict/increase in positive behaviors

Other; \_\_\_\_\_

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Person(s) Attending Sessions Signature(s)

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Date \_\_\_\_\_

\_\_\_\_\_  
Date \_\_\_\_\_

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Date \_\_\_\_\_

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Date \_\_\_\_\_

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Therapist Signature

\_\_\_\_\_  
Date \_\_\_\_\_

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