



## INDIVIDUAL REHABILITATION PLAN

<b>Client Name:</b>	<b>Age:</b>	<b>DOB:</b>
____ <b>Initial Rehabilitation Plan</b>	____ <b>Rehabilitation Plan Review</b>	<b>Date:</b>
<b>MA#:</b>		

**DSM-V BEHAVIORAL DIAGNOSIS**

<b>DSM-5</b>			
<b>Behavioral</b>			
Diagnostic Category:	Code:	Description:	
Diagnostic Category:	Code:	Description:	
Diagnostic Category:	Code:	Description:	
<b>Medical</b>			
Diagnostic Category:	Code:	Description:	
Diagnostic Category:	Code:	Description:	
Diagnostic Category:	Code:	Description:	
<b>Social elements Impacting Diagnosis (Check all that apply)</b>			
<input type="checkbox"/> None	<input type="checkbox"/> Problems with access to healthcare services	<input type="checkbox"/> Housing problems (not homelessness)	<input type="checkbox"/> Problems related to the social environment

Client Name:

<input type="checkbox"/> Education Problems	<input type="checkbox"/> Problems related to interactions with legal system/crime	<input type="checkbox"/> Occupational problems	<input type="checkbox"/> Homelessness
<input type="checkbox"/> Financial problems	<input type="checkbox"/> Problems with primary support groups	<input type="checkbox"/> Other psychological and environmental problems	<input type="checkbox"/> Unknown
<b>Functional Assessment</b>			
Date of Diagnosis:		Assessment Measure/Score:	
Measure:		Name and Title:	

**SECTION II**

**A. PROBLEMS/NEEDS IDENTIFIED IN THE DIAGNOSTIC ASSESSMENT:**

Client therapist reported that client has anger issues, parental separation issues, and adjustment disorder. Client mother reported that client is often in trouble in school due to client being unable to manage his anger. Client doesn't have many friends. Client is sensitive to hearing and the school works with client with headphones. Client had several school suspensions.

**B. ISSUES WITH SUBSTANCE ABUSE DOCUMENTED IN THE ASSESSMENT: \_\_\_ YES OR \_\_\_ NO (IF YES SUBSTANCE ABUSE GOAL MUST BE DEVELOPED)**

**C. ARE DISABILITIES OR CO-OCCURRING DISORDER DOCUMENTED IN THE ASSESSMENT: \_\_\_ YES OR \_\_\_ NO (IF YES INCORPORATE INTO THE GOALS)**

**SECTION III: TREATMENT GOALS (MUST BE MEASURABLE, ATTAINABLE, APPROPRIATE AND INDIVIDUALIZED)**

**Long Term Goal #1:**

**Objective of Long Term Goal #1:**

Short Term Goals	Frequency	Intervention	Target Date	Progress
Goal #1				Progress: (for reviews only) None ___ Mild ___ Moderate ___

Client Name:

				Successfully Achieved _____
<b>Goal #2</b>				Progress: (for reviews only) None _____ Mild _____ Moderate _____ Successfully Achieved _____
<b>Goal #3</b>				Progress: (for reviews only) None _____ Mild _____ Moderate _____ Successfully Achieved _____

**Update on Progress for Goal 1:**

**Long Term Goal #2:**

**Objective of Long Term Goal #2:**

<b>Short Term Goals</b>	<b>Frequency</b>	<b>Intervention</b>	<b>Target Date</b>	<b>Progress</b>
<b>Goal #1</b>				Progress: (for reviews only) None _____ Mild _____ Moderate _____ Successfully Achieved _____
<b>Goal #2</b>				Progress: (for reviews only) None _____ Mild _____ Moderate _____ Successfully Achieved _____
<b>Goal #3</b>				Progress: (for reviews only) None _____ Mild _____ Moderate _____ Successfully Achieved _____

**Update on Progress for Goal 2:**

Client Name:

**Long Term Goal #3:**

**Objective of Long Term Goal #3:**

<b>Short Term Goals</b>	<b>Frequency</b>	<b>Intervention</b>	<b>Target Date</b>	<b>Progress</b>
<b>Goal #1</b>				<b>Progress: (for reviews only)</b> None ____ Mild ____ Moderate ____ Successfully Achieved ____
<b>Goal #2</b>				<b>Progress: (for reviews only)</b> None ____ Mild ____ Moderate ____ Successfully Achieved ____
<b>Goal #3</b>				<b>Progress: (for reviews only)</b> None ____ Mild ____ Moderate ____ Successfully Achieved ____

**Update on Progress for Goal 3:**

**SECTION IV:**

- A. Client Strengths:** Client is a very outgoing young man. He is very family oriented and has no problem taking on the responsibility of taking care of his younger brother.
- B. Client Abilities:** Client is very good at coloring and loves participating in sports
- C. Client Preferences:** Client feels more comfortable learning in an active setting. He loves multi-tasking and working on new projects.
- D. Client Weaknesses:** Client has issues with his anger. When being put in a negative setting he will fight and resort to violent actions.

Client Name:

E. Current Medications:

F. Coordination of Supportive Services/Providers:

G. Any Needs Beyond the Scope of AGS PROGRAMS and Referrals Made:

H. Discharge Plan (Include the goals that the Consumer needs to accomplish in order for the transition/discharge to occur, the supports needed at time of discharge/transition, and an estimated timeframe within which the transition/discharge will realistically occur):

I. What community supports or services are needed for discharge:

J. Consumer will be ready for discharge when: He has completed each of his goals.

K. Expected Date of Discharge: 9-1-2016

**SECTION V:**

Has consumer received/signed a copy of IRP     Yes     No (Explain if No):

*By signing below you are indicating that you have reviewed this rehabilitation plan:*

	<u>Name (printed)</u>	<u>Name (signed)</u>	<u>Relation to Client</u>	<u>Date</u>
Client				
Parent/Guardian				
Clinician/credentials				
Rehab Specialist				
Rehab Coordinator				

Client Name: