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MY WELLNESS JOURNEY

PATIENT NAME _____ DOB _____

THE MAIN REASON I AM SEEKING THERAPY IS:

MY MOST IMPORTANT GOALS FOR THERAPY ARE:

1. _____

2. _____

3. _____

I KNOW I AM COMPLETE WITH THERAPY WHEN:

*****THERAPIST ONLY*****

FREQUENCY/DURATION: _____

THERAPY PLAN OF CARE:

PATIENT SIGNATURE: _____