Client Name: _____ **Client #:**_____ **Adm. Date:** _____

Community Counseling of Central Connecticut Inc.
53 Muir Ave Bristol, CT. 06010
860-582-7904 cccofcentralct.org
We treat people not privilege…

Initial Treatment Plan

Immediate Needs:

[] Individual Sessions	[] Family/SO Contact	[] Interpreter
[] Couples Counseling	[] Employer Contact	[] Mentor
[] Group Counseling	[] Hygiene Education	[] Support Group
[] Psychiatric Evaluation	[] Physical Eval	[] Referral to State Agency
[] Other	[] Family Therapy	

To be addressed:

[] TX options	[] Family	[] Aftercare Planning
[] Community Resources	[] Occupational	[] Financial
[] Nutrition	[] Living Arrangements	[] Psych Concerns
[] Medical Concerns	[] Legal	[] Recidivism
[] Educational	[] Relationship Issues	[] Substance Use/Abuse
[] Stress Management	[] Anxiety	[] Denial
[] Depression	[] Trauma	[] Other: _____

Collateral Contact: (if any)

[] Significant Other	[] Family	[] MD/ Psychiatrist
[] Social Worker	[] Probation/ Parole	[] Teacher [] Other _____

Continuing Care Plan: (if additional to above marked)

1. _____
2. _____
3. _____
4. _____

Clinician Signatures:

_____ **Date:** _____

Dr. Warren Corson III LPC, NCC, ACS.