Associates In Mental Health Administrative Office
1155 N. State St. Suite 404 Bellingham, WA 98225

(360) 715-2488 Phone
(360) 671-1842 Fax

Treatment Goals

Client Name: _____ **Date**: _____/_____/_____

I. Please list issues to discuss in therapy which are of primary concern to you at present:

II: Please list any specific goals or changes you would like to accomplish: