

Goals of Counseling

Name: _____ Date: _____

Problem Areas/Goals "In the area of ___ I would like:"	Intervention	Time Frame
1. Marijuana use/nonuse		
2. Alcohol use/nonuse		
3. Other drug use/nonuse		
4. Relationship with boyfriend, girlfriend, spouse		
5. Relationships with friends		
6. Relationships with parents/family		
7. School		
8. Work		
9. Social activities		

Goals of Counseling

Name: _____ Date: _____

Problem Areas/Goals "In the area of ___ I would like:"	Intervention	Time Frame
10. Recreational activities		
11. Personal habits (e.g. getting up in the morning, being on time, finishing tasks)		
12. Legal issues		
13. Money management		
14. Emotional life (my feelings)		
15. Communication		
16. General happiness		
17. Other:		

(Participant Signature) _____ (Date) _____ (Clinician Signature) _____ (Date)

(Guardian Signature – Optional) _____ (Date) _____ (Supervisor Signature) _____ (Date)