How to create a treatment plan in SimplePractice

This guide explains how to create a treatment plan in SimplePractice, starting with a diagnosis and ending with a saved, signed plan in your client's record. You choose a diagnosis code, pick a treatment plan template, and link goals, objectives, and interventions. You also set a treatment frequency and a review reminder. The guide ends with how to update the plan later.

Prerequisites

Before you start, make sure you have the following:

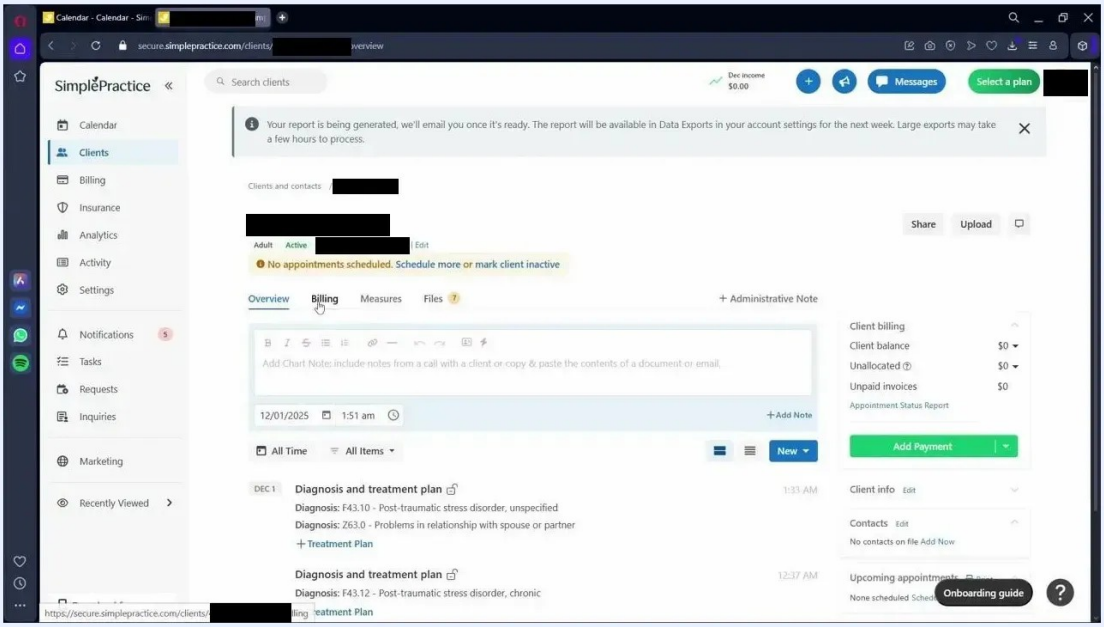
- A SimplePractice account that you can log in to
- A client in your **Clients** list

Step 1: Open the client's overview page

The client's overview page is the hub for demographics, documentation, and clinical notes. You start here to create a treatment plan in SimplePractice.

1. Open SimplePractice and log in.
2. In the left sidebar, select **Clients**.

3. Find your client in the list and select their name.



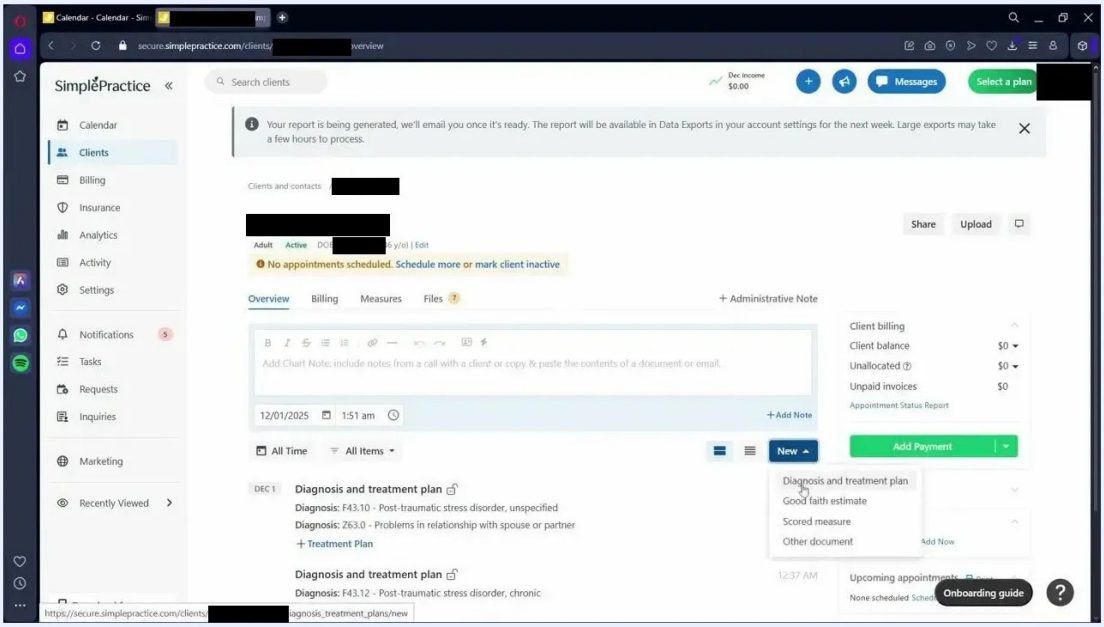
Clients list and navigation to the client overview page

Step 2: Start a new diagnosis and treatment plan

This opens the workspace where you set up the clinical foundation of care.

1. On the client's overview page, click **New**.

2. From the dropdown, select **Diagnosis and treatment plan**.



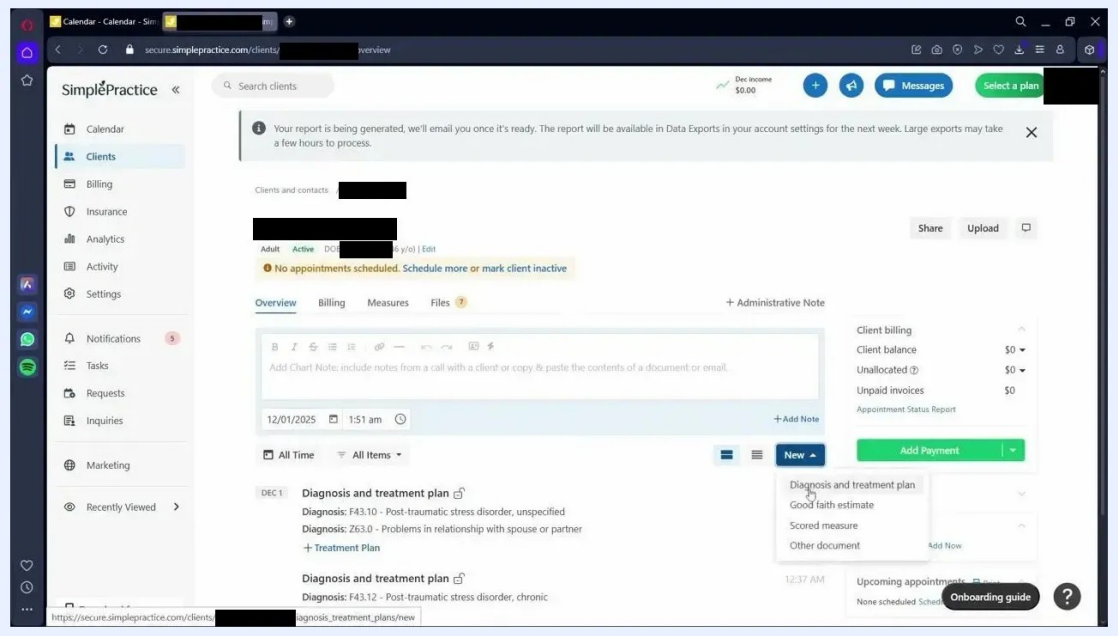
Client overview page with the New button and the Diagnosis and treatment plan option in the dropdown

Step 3: Select the diagnosis codes

The diagnosis comes first in the treatment plan, so you add it before you write the plan.

1. In the Diagnosis section, click the field to search for and select the ICD-10 diagnosis code that fits your client. For example, select F43.21 - Adjustment disorder with depressed mood.
2. If your client has co-occurring conditions, add more than one diagnosis to reflect the full clinical picture.
3. Enter the date and time of the diagnosis, for example 12/01/2025, 1:51 am.

4. Click **Save** to confirm the diagnosis.



Diagnosis code selection and date fields

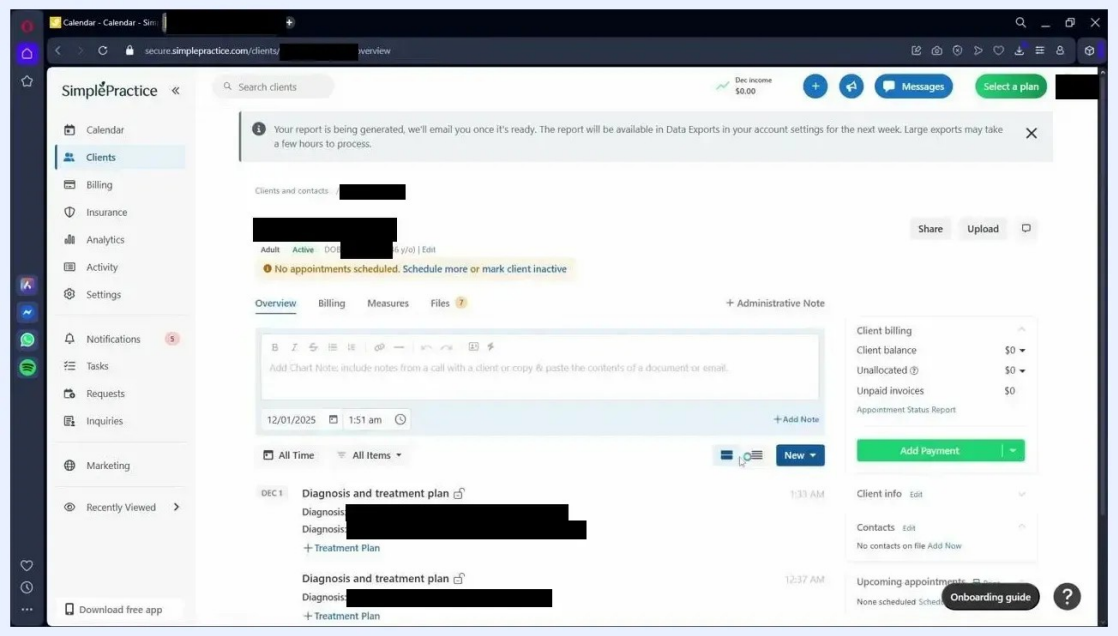
Step 4: Choose a treatment plan template

After you save the diagnosis, move on to the Treatment Plan section.

1. Click the **Choose one** dropdown under Treatment Plan.
2. Select the template that fits your workflow:

- **Simple**: Capture your plan in a single text box.
- **Basic**: Write quick plans, broken out by presenting problem, goal, and objective.
- **Advanced**: Create step-by-step plans with multiple fields.

You can also use a custom template. If it's available to you, you can use a Wiley treatment planner for curated objectives and interventions.



Treatment plan template dropdown with the Simple, Basic, and Advanced options

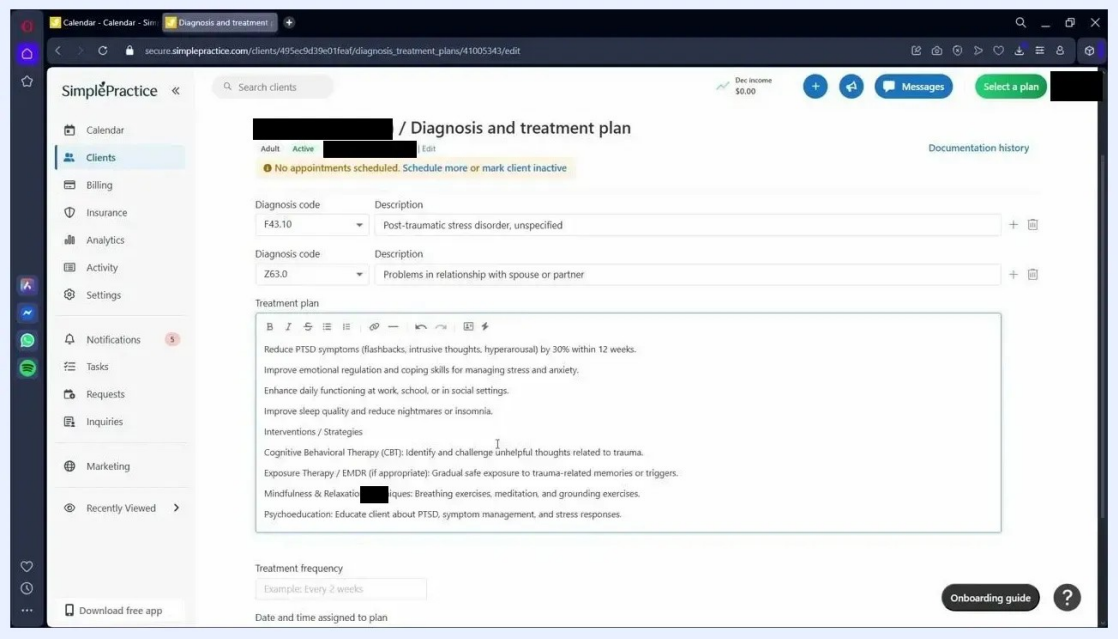
Step 5: Link the diagnosis, goals, objectives, and interventions

Make sure each diagnosis is clearly connected to specific goals, measurable objectives, and targeted interventions. Write objectives that are time-bound and observable, so you can track and review progress. For example: "Reduce PTSD symptoms by 30% within 12 weeks."

Document the details in the Treatment Plan text area, including:

- Goals, for example "Improve emotional regulation and coping skills for managing stress and anxiety."
- Objectives, for example "Enhance daily functioning at work, school, or in social settings."

- Interventions and strategies, for example "Cognitive Behavioral Therapy (CBT): Identify and challenge unhelpful thoughts related to trauma."

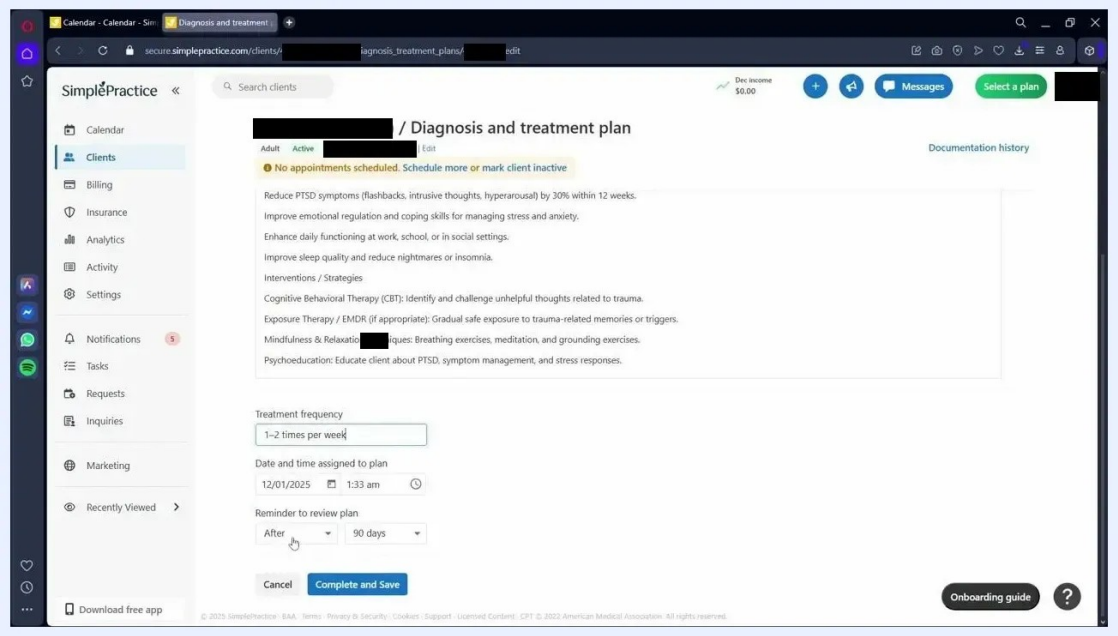


Completed treatment plan fields with linked diagnosis, goals, objectives, and interventions

Step 6: Set the treatment frequency and plan date

1. Enter the treatment frequency in the provided field, for example "1–2 times per week."

2. Set the date and time assigned to the plan, for example 12/01/2025, 1:33 am. This establishes when the plan takes effect.



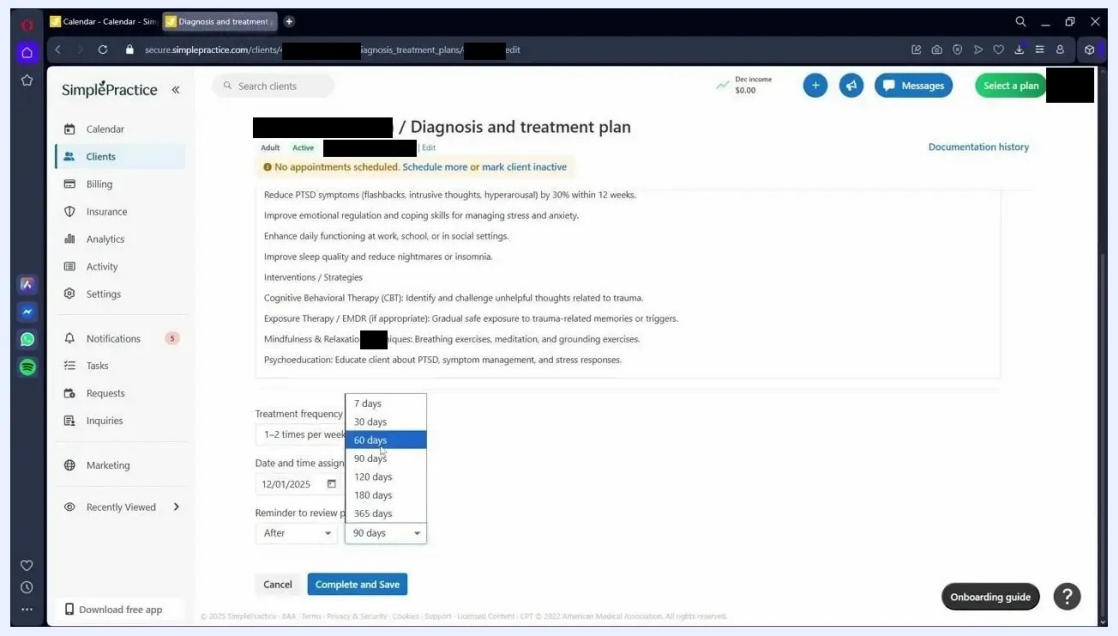
Treatment frequency and plan assignment date fields filled out

Step 7: Add a reminder to review the plan

A review reminder helps keep the plan current and clinically relevant.

1. Open the "Reminder to review plan" dropdown.
2. Select an interval that matches your practice or payer requirements, for example "After 90 days."

You can choose 7, 30, 60, 90, 120, 180, or 365 days.



Dropdown menu for selecting the plan review reminder interval

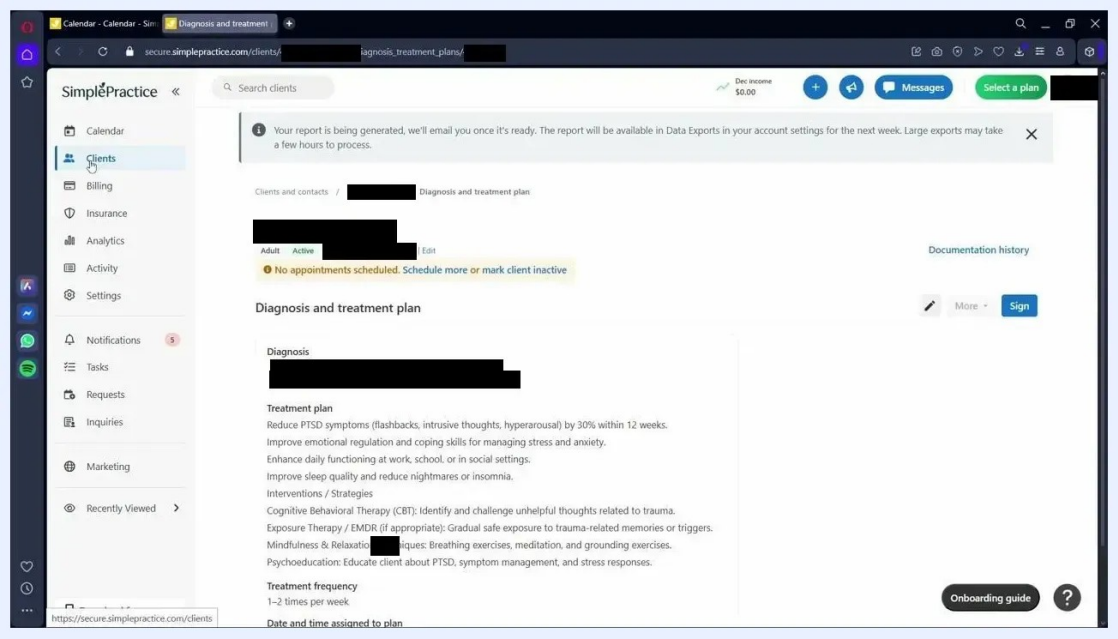
Step 8: Complete and save the treatment plan

1. Review all entries for accuracy and completeness.
2. Click **Complete and Save** to store the plan in the client's record.

The plan is now organized alongside the client's other clinical documents for easy access.

Step 9: Sign the plan, if required

If your workflow or payer requires it, click **Sign** to finalize the plan. A signed plan is locked for editing and stored as part of the client's permanent clinical record.



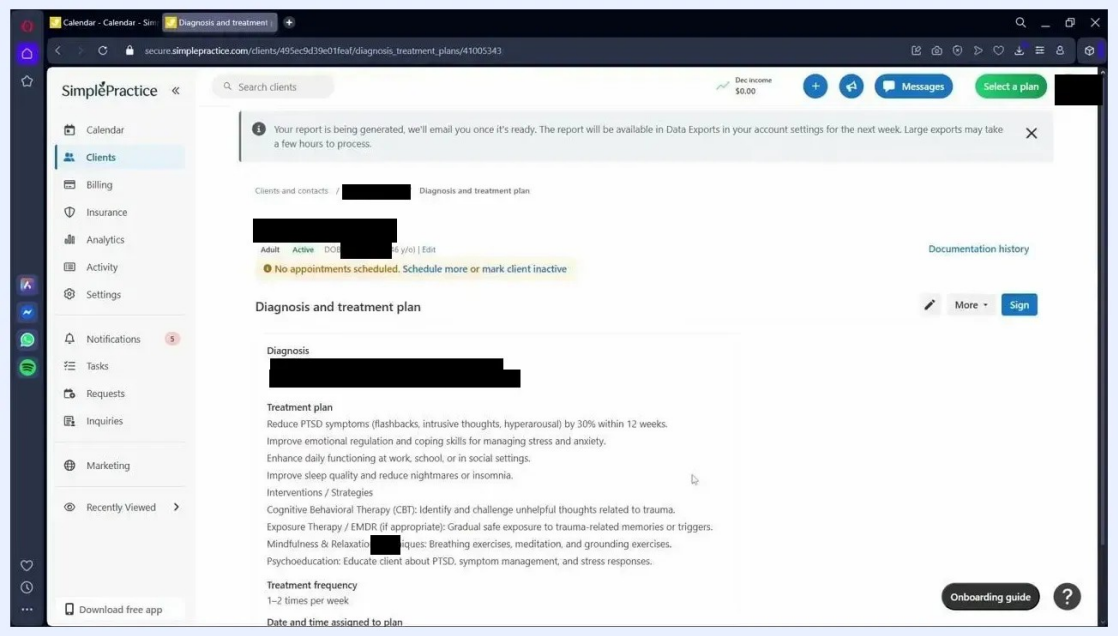
Diagnosis and treatment plan with the sign option in the client record

Step 10: Update the treatment plan as needed

You can change the plan later without losing earlier versions.

1. Return to the client's overview page.
2. Open the existing treatment plan and make your edits.
3. Click **Update**.

Updating preserves the history of previous plans while keeping the active plan accurate and actionable.



Saved diagnosis and treatment plan summary in the client record

Summary

You now know how to create a treatment plan in SimplePractice. You add a diagnosis, choose a template, and link goals, objectives, and interventions. You also set the frequency, plan date, and review reminder, then save and, if needed, sign the plan. The result is a clear, measurable, and actionable plan that supports clinical care and streamlines documentation.

What's next

When your client's needs change, open the existing plan from their overview page and click **Update** to keep it current.