



WHITE OAK Counseling and Recovery

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Treatment Goal Inventory

Client Name: _____ Client #: _____

In the list below, please check items you would like your counselor to help you with.	
<input type="checkbox"/>	Object Relations
<input type="checkbox"/>	Social Skills
<input type="checkbox"/>	Self-Expression
<input type="checkbox"/>	Conflict Resolution
<input type="checkbox"/>	Limit-setting
<input type="checkbox"/>	Initiative
<input type="checkbox"/>	Impulse Control
<input type="checkbox"/>	Self-control
<input type="checkbox"/>	Frustration tolerance
<input type="checkbox"/>	Patience
<input type="checkbox"/>	Procrastination
<input type="checkbox"/>	Affect and Mood
<input type="checkbox"/>	Feeling Awareness
<input type="checkbox"/>	Relaxation
<input type="checkbox"/>	Feeling Expression
<input type="checkbox"/>	Letting go, grief and loss
<input type="checkbox"/>	Reality Testing
<input type="checkbox"/>	Understanding others
<input type="checkbox"/>	Being in the here-and-now
<input type="checkbox"/>	Self-reflection, self-awareness
<input type="checkbox"/>	Self Functions
<input type="checkbox"/>	Self-confidence
<input type="checkbox"/>	Trusting
<input type="checkbox"/>	Self-esteem
<input type="checkbox"/>	Self-care

Client Signature

____/____/____
Date

Counselor Signature

____/____/____
Date