

Name _____ DOB ____ / ____ / ____ Date _____

PERSONAL CRISIS PLAN

My Triggers: _____

Thoughts/Inside Warnings: _____

Outside Warning Signs: _____

When Notice My Triggers I will: _____

When Others Notice I'm Upset I'd like them to: _____

Things That Help Me Stay Better Now: _____

Things That Help Me Stay Well on a Regular Basis: _____

Things That Make Me Feel Worse: _____

*If I'm feeling unsafe, I will go to the ER of local hospital, call Suicide Hotline 1-800-273-8255, or call my county's crisis number.

Patient Signature _____ Date _____
(If patient is a minor (ages 14-18) he/she must sign this Registration-Assignment/Release/Consent to Treatment)

Print Name _____

Responsible Party Signature _____ Date _____
(Parent/Guardian/Legal Representative)

Print Name _____

Relationship to Patient _____
(Guardian/Legal Representative is required to attach supporting legal documentation)

Office use only

Witness _____ Name _____ Date _____