Uncommon Sense LLC

404.500.7289 | | uncommonsenseliving.com

SELF-CARE PLAN

1. People that participate in therapy sometimes experience one or more of the following conditions:
   - Self-harm (thoughts/feelings/behaviors to hurt, cut, hit, burn, etc. one's self)
   - Aggression (thoughts/feelings/behaviors to hurt, break things, threaten, cut, hit, burn, etc. others)
2. If you ever experience such thoughts, feelings, or behaviors, this document is a Self-Care Plan intended to facilitate you in seeking out help and assistance.
3. By signing this document you are agreeing to the following statements and actions:

   (a.) I understand that there are people available to help me.

   (b.) I also understand that getting the help and assistance I need might take some time.

   (c.) I agree not to do anything to harm myself or others in any way while I am seeking out help and assistance. This includes any kind of overt or passive acts of danger to myself or others.

   (d.) Overt acts are intentional acts to harm myself or others. Passive acts involve putting myself or others in possible danger, such as not looking when crossing a street or engaging in unprotected sexual activities.

   (e.) If, at any time, I should feel unable to resist impulses to self-harm, to act-out aggressively, or to engage in harmful behaviors, I agree to do several of the following options:
   - Self-care activities: _____
   - _____
   - _____
   - Call a relative, friend, or sponsor:
     Name: _____ Phone: _____
     Name: _____ Phone: _____
     Name: _____ Phone: _____
     Name: _____ Phone: _____
   - Call Behavioral Health Link/GCAL: 800-715-4225
   - Call Ridgeview Institute at 770-434-4567
   - Call Peachford Hospital at 770-455-3200
   - Visit a local Emergency Room
   - Call 911

   (f.) I also agree to call my therapist at Uncommon Sense and tell him or her. I understand that my therapist will return my call within 48 hours unless otherwise negotiated.
4. This Self-Care Plan begins immediately and will remain in effect for the duration of your therapy with Carroll Coplin. Your agreement to this plan illustrates your commitment to work through any thoughts, feelings, and behaviors at this time as well as in the future.
5. Your signature below indicates that you have read and understand what is being requested of you, and you agree to uphold this Self-Care Plan without exception.
6. Please cut out this quick reference sheet and place in your wallet.

_____
Recipient of Services (Signature/Date)

_____
Parent/Guardian (Signature/Date)

_____
Therapist (Signature/Date)

SELF-CARE PLAN (please keep in your wallet)
- Self-care activities: _____
  _____
  _____
- Call a relative, friend, or sponsor:
  - Name: _____ Phone: _____
  - Name: _____ Phone: _____
  - Name: _____ Phone: _____
  - Name: _____ Phone: _____
- Call Behavioral Health Link/GCAL: 800-715-4225
- Call Ridgeview Institute at 770-434-4567
- Call Peachford Hospital at 770-455-3200
- Visit a local Emergency Room
- Call 911