

Safety Plan

Client Name

Client ID

Effective Date

Author

Safety Plan

When I am Doing Well

How do you feel when things are going well in your life?

My Warning Signs of Potential Crisis

What feelings, thoughts, or beliefs would help you recognize that a crisis may be starting?

Ways to Support Myself

What are some healthy strategies, activities, (hobbies, interests, etc.) you enjoy that help you focus on taking care of yourself?

Coping Skills

What are some positive coping strategies to use in moments when you are feeling overwhelmed or anxious?

People or Social Settings that Provide Support

What connections do you have with family, friends, faith groups, communities, or pets? Where do you feel safe and supported? Who is the person(s) and contact(s) that you can openly talk about your crisis with?

Connections with Professionals or Agencies I Can Reach Out to When I am in a Crisis

Include the person's/agency's name and contact information. Include local emergency departments and phone numbers.

Ways to Make My Environment Safe

Are there things you can remove or put away to help keep you safe? Are there any firearms/weapons in your home that can be stored safely? Is there someone who can support you with this?

Client Signature		Date	
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Parent/Guardian Signature (if applicable)		Date	
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Parent/Guardian Printed Name(if applicable)			
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Program Name			
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Provider Signature		Date	
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Provider Printed Name & Credentials			
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