

# Treatment Contract

This treatment contract specifies my limits and preferences in accepting help to manage my bipolar disorder. It is intended to help my support person, \_\_\_\_\_, determine when I need help and the type of help I prefer when specific symptoms are present.

## I am able to manage my bipolar disorder when I'm doing the following:

- \* Sleeping regularly: \_\_\_\_\_ to \_\_\_\_\_ hours per night
- \* Attending work/school
- \* Seeing my doctor/therapist \_\_\_\_\_ every \_\_\_\_\_ month/year
- \* Taking my medications as prescribed
- \* Getting together with friends or family \_\_\_\_\_ times a week
- \* Communicating with others without arguing
- \* Other: \_\_\_\_\_

## You should be concerned when you notice any of the following symptoms:

- \* Sleeping fewer than \_\_\_\_\_ hours per night or more than \_\_\_\_\_ hours per day
- \* Missing work/school
- \* Crying almost every day
- \* Not showering or dressing up as I usually do
- \* Shopping more than usual and buying impulsively
- \* Gambling or engaging on other risky activities
- \* Talking a lot more and faster than usual
- \* Other: \_\_\_\_\_

## When you observe \_\_\_\_\_ or more symptoms lasting for more than \_\_\_\_\_ hours/days, you can help me by:

- \* Asking me how I'm doing
- \* Spending more time with me and encouraging me to go out
- \* Taking my credit cards and medications
- \* Taking my car keys
- \* Calling my doctor/therapist
- \* Staying with me until I get help
- \* Other: \_\_\_\_\_

## If you need to contact my doctor or therapist:

Dr. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Therapist: \_\_\_\_\_ Phone: \_\_\_\_\_

## In case of emergency:

Emergency room: \_\_\_\_\_ Phone: \_\_\_\_\_

Mental Health Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

## You may do whatever you deem is best if you believe that I may harm myself or others.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_