Bipolar Treatment Plan

Name: _____ Date of birth: _____ dd / mm / yyyy

Gender: _____ Phone number: _____

Email address: _____

Address

MEDICAL HISTORY

Medical Conditions

Suicide History

Medications

Substance Use History

Drug Allergies

Family History

Psychiatric History

TREATMENT PLAN

Medication

Cognitive-behavioral therapy

◯ Yes ◯ No

If yes, specify with notes

Stress reduction techniques

◯ Yes ◯ No

If yes, specify with notes

Physical activity

◯ Yes ◯ No

If yes, specify with notes

Support group

◯ Yes ◯ No

If yes, specify with notes

PROGRESS MONITORING

Frequency and severity of mood swings

Quality of life measures

Side effects of medication

Attendance and engagement in therapy and support groups

Levels of stress and physical activity

NEXT STEPS

Next Steps