Relapse Prevention Plan

Name: _____ Date: _____

Coping Skills: List activities or skills you enjoy that can get your mind off of using.

1	
2	
3	

Social Support: Who are three people you can talk to if you are thinking about using?

1	
2	
3	

Consequences: How will your life change if you relapse? How about if you stay sober?

Outcomes of Relapse	Outcomes of Sobriety