Suicide Assessment Form

Date: __________ Time of Day: __________ Day: S M T W R F S Staff Member conducting assessment: __________

Client seen at which agency: __________________________________________ □ in-person □ by phone □ On-call staff

Client expressed thoughts or feelings of suicide: □ Yes □ No

<table>
<thead>
<tr>
<th>Indicators/Risk Levels</th>
<th>Very low risk</th>
<th>Mild/low risk</th>
<th>Moderate risk</th>
<th>Severe/high risk</th>
<th>Extremely high risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Method(s) Considered</td>
<td>□ Vague, no plan</td>
<td>□ Pills, slash wrist</td>
<td>□ Drugs, alcohol, car wreck, some specifics</td>
<td>□ Gun, hanging, jumping; some specifics</td>
<td>□ In progress; gun, hanging, jumping; very specific knows how, when, where</td>
</tr>
<tr>
<td>Suicidal Plans</td>
<td>□ None</td>
<td>□ None</td>
<td>□ Some but no clear intent.</td>
<td>□ Developed plan with considerable detail.</td>
<td>□ Well-thought out, lethal plans.</td>
</tr>
<tr>
<td>Availability of Means</td>
<td>□ No plan; no availability of means</td>
<td>□ Not available-will have to get</td>
<td>□ Available but not close by</td>
<td>□ Available-have close by</td>
<td>□ Have in hand or in progress</td>
</tr>
<tr>
<td>Suicidal Behavior</td>
<td>□ None</td>
<td>□ Ideation</td>
<td>□ Threat</td>
<td>□ Attempt low lethal</td>
<td>□ Attempt high lethal</td>
</tr>
<tr>
<td>When Attempt is Planned</td>
<td>□ No attempt planned</td>
<td>□ 48 hours or more</td>
<td>□ 24 to 48 hours</td>
<td>□ 24 to 18 hours</td>
<td>□ Presently (In progress) or within 24 hours</td>
</tr>
<tr>
<td>Previous suicide attempt(s)</td>
<td>□ None</td>
<td>□ None</td>
<td>□ Yes (One to Five Years ago)</td>
<td>□ Yes (Three months to one Year ago)</td>
<td>□ Yes (Three months ago or less)</td>
</tr>
<tr>
<td>Feelings of Loneliness</td>
<td>□ Hardly ever</td>
<td>□ Sometimes; support system present</td>
<td>□ Usually; some support system</td>
<td>□ Always; limited support system</td>
<td>□ Always; No support system</td>
</tr>
<tr>
<td>Hope/Level of Ambivalence</td>
<td>□ Hopeful; Readily acknowledges desire to live</td>
<td>□ Some hope, aware of some desire to live</td>
<td>□ Hope and some desire to live present, but inconsistent or limited.</td>
<td>□ Little or no hope for future; does acknowledge some ambivalence</td>
<td>□ No hope. Does not consciously acknowledge any ambivalence</td>
</tr>
<tr>
<td>Intoxication (Use of alcohol or drugs)</td>
<td>□ Has not been drinking or using drugs</td>
<td>□ Limited use of alcohol</td>
<td>□ Limited use of alcohol or drugs; past history of substance abuse treatment</td>
<td>□ Intoxicated; mixing drugs and alcohol</td>
<td>□ Mixing drugs and alcohol and evidence of intoxication</td>
</tr>
<tr>
<td>Chance of Intervention</td>
<td>□ Others present</td>
<td>□ Others expected</td>
<td>□ Others expected or available</td>
<td>□ Others available</td>
<td>□ No one nearby; isolated</td>
</tr>
</tbody>
</table>

Emotions and behavior during session:
□ Confusion □ Normal □ Flat □ Crying □ Depressed □ Difficulty Talking
□ Anxiety □ Agitated □ Hostile □ Intoxicated □ Unresponsive □ Other: ___________________________

Symptoms of Depression:
□ Trouble Sleeping □ Changes in Appetite □ Changes in Weight □ Inability to perform daily tasks
□ Loss of Energy □ Hopelessness □ Helplessness □ Other ___________________________

Recent Loss or Potential Loss, defeat, humiliation, betrayal, perceived failure? □ yes □ no If so, when? Describe: ___________________________

Sense of being a burden or a disappointment to others? □ Yes □ No

Grateful acknowledgment to the Crisis Center from which this was adapted. (2016)
Client’s Name: __________________________ Telephone #: __________________________ Age: ____________

Describe Current Problem (crisis information, reason for session, current stressor, presenting problem):
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Describe in detail the plan and means (i.e. kind of pills, how many, dosage, access to gun, etc.):
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Suicidal Communication made to:  □ Counselor/Therapist  □ Significant Others  □ Family Member  □ Friend  □ Other ____________

Support System and External Resources (family, friends, significant other, professional):
Name and Telephone: ____________________________________________________________
Name and Telephone: ____________________________________________________________
Name and Telephone: ____________________________________________________________

Counseling / Therapy:  □ None  □ Prior  □ Current  Describe: ____________________________
Military/Veteran/Nat’l Guard:  □ Yes  □ No  Describe: ________________________________
DSM Diagnosis?  □ yes  □ no  Describe: ____________________________________________
Prior Hospitalization?  □ yes  □ no  When? ______________  Describe: ____________________
Prior History of a Suicide Attempt: □ yes  □ no  When? ______________  Describe: __________
Family history of suicide attempts?  □ yes  □ no  Describe: ___________________________
Client’s Attitude Toward Help: □ Accepts  □ Rejects  Describe: ________________________

Resolution of Session: □ No specific action taken or referral made  □ Reinforced current therapy/counseling
□ Family, friends, or significant other called  □ Referral made to other agencies, explain below
□ Engaged emergency help (ambulance, police, transport, etc.)  □ Other, explain below

Explain resolution: ________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Suicide Risk: □ low  □ moderate  □ high  Emergency / Acute Risk: □ low  □ moderate  □ high  Chronic □ yes  □ No
Follow up needed?  □ yes  □ no  Date and Time: __________________________
Best contact information for follow up: ______________________________________________
Safety Plan developed: □ yes  □ no 
Notes: __________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Staff Member Signature: ___________________________________________________________ Date: ____________

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