

Client's Name: _____ Telephone #: _____ Age: _____

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

Checklist for Assessing Emergency Risk for Suicide – check-mark, highlight, or circle criteria below that are met:

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

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

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:** _____

Prior History of Trauma and/or bullying? 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:** _____