SUICIDE ASSESSMENT

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Patient's Name: _____Date/time_____

Notes: this assessment is to be completed at the time of intake and when there is any suicidal threats or behavior that indicated crisis.

1. Has anyone in your family ever attempted suicide? _____yes _____no
2. Has anyone in your family ever committed suicide? _____yes _____no
3. Have you ever thought of killing yourself? _____yes _____no
4. Have you ever attempted suicide? _____yes _____no
5. If patient answered yes to any of this questions, explain _____yes _____no

   _____

   _____
6. Do you feel like killing yourself now? _____yes _____no
7. Do you have a plan on how to kill yourself? _____yes _____no
8. If patient answered yes to number 7 please described the plan _____

   _____
9. Do you have access to the method of killing yourself? _____yes _____no
10. If patient answered yes to number 9 please explain?

    _____

    _____
11. On a scale of 1 to 10 and 10 being the most serious desire to kill yourself, how would you score yourself now? _____
12. If your answer is yes on questions #6, are you willing to go to the hospital? _____yes ____no

_____ _____

Patient's Signature Date

_____ _____

Mental Health Counselor Date