Suicide Risk Assessment

ID# 230

Columbia Suicide Risk Assessment

☑ Columbia Suicide Risk Assessment

Date assessed:

Ask Questions 1 and 2

1. Within the past month, have you wished you were dead or wished you could go to sleep and not wake up? Y | N

2. Within the past month, have you actually had any thoughts of killing yourself? Y | N

If YES to 2, ask questions 3, 4, 5, and 6. If NO, go directly to question 6.

3. Have you been thinking about how you might kill yourself? Y | N

4. Have you had these thoughts and had some intention of acting on them? Y | N

5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? Y | N

6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? Y | N

If YES, How long ago did you do any of these?

- ☐ Over a year ago
- ☐ Between three months and a year ago
- ☐ Within the last three months

Additional information / Follow Up:

Complete

Crisis Planning

Safety Plan

The Guidance Center

Triggers:

When these things happen, I am more likely to feel unsafe or upset

- ☐ **Not being listened to/not having control**
- ☐ **Loud noises**
- ☐ **Problems at work or school**
- ☐ **Feeling unwell**
- ☐ **Difficulties with family, friends , co-workers, etc.**
- ☐ **Loss of a loved one**
- ☐ **Financial problems / stressors**
- ☐ **Particular Person:** _____
- ☐ **Time of Day and/or Year/Anniversary Loss:** _____
- ☐ **Being isolated/feeling lonely**
- ☐ **Relapse**
- ☐ **Being stared at or touched**
- ☐ **Hearing voices**
- ☐ **Darkness**
- ☐ **People yelling/arguments**
- ☐ **Other:** _____

Inside Warning Signs:

These are things **I may notice** just before I feel unsafe or upset

- ☐ **Thoughts of hurting myself/others**
- ☐ **Hallucinating**
- ☐ **Negative thoughts**
- ☐ **Feeling disoriented**
- ☐ **Feeling anxious, nervous, or paranoid**
- ☐ **Wanting to destroy things**
- ☐ **Feeling unwell**
- ☐ **Cravings to use drugs and/or alcohol**
- ☐ **Change in appetite**
- ☐ **Other:** _____

Outside Warning Signs:

These are things **other people may notice** just before I feel unsafe or upset

- ☐ **Change in appearance**
- ☐ **Eating more/less**
- ☐ **Refusing to take my medication**
- ☐ **Sleeping more/less**
- ☐ **Paranoia**
- ☐ **Using drugs and/or alcohol**
- ☐ **Change in physical behavior**
- ☐ **Change in emotional behavior**
- ☐ **Change in aggressive behaviors**
- ☐ **Other:** _____

Risk Assessment:

The following checked items increase my risk for crisis

- ☐ **Access to firearms or sharp objects**
- ☐ **I feel I am in an unhealthy relationship**
- ☐ **Access to drugs or illegal substances**
- ☐ **Med change or not taking prescribed medication**
- ☐ **No identified natural supports/family discord**
- ☐ **Being isolated for a long period of time**
- ☐ **Recent loss of person, home, job, or belonging**
- ☐ **Legal involvement**
- ☐ **Prior or current suicidal ideation**
- ☐ **Family history of suicide**
- ☐ **Major Depressive Disorder Diagnosis**
- ☐ **Financial difficulties**
- ☐ **Sleep difficulties**
- ☐ **Other:** _____

Crisis Planning

Safety Plan

The Guidance Center

Things that help me feel better and stay more in control:

These are things that help me calm down, stay safe, or things I might like to try in the future

- ☐ **Talking with friends, family, & peers**
- ☐ **Relaxing**
- ☐ **Taking my medication**
- ☐ **Deep breathing**
- ☐ **Exercising**
- ☐ **Talking to my therapist or support staff**
- ☐ **Partaking in my favorite hobby**
- ☐ **Other:** _____

Resiliency Factors:

- ☐ **Sense of meaning and purpose in life**
- ☐ **Religious or spiritual practice**
- ☐ **Identified natural supports/supportive family**
- ☐ **Positive help-seeking behaviors**
- ☐ **Stable housing**
- ☐ **Stable income**
- ☐ **Sense of hope or optimism**
- ☐ **Doing well at school or work**
- ☐ **Good health care practices**
- ☐ **Engagement in activities**
- ☐ **Other:** _____

Crisis Contacts:

These are the names and numbers of individuals I can contact during a crisis

1. Call **911** for immediate physical danger
2. Present to the Emergency Room at the nearest hospital for assistance and evaluation

   Hospital Name: _____

   Hospital Address: _____
3. Call the **24-hour Crisis Hotline at 1-814-362-4623** or 1-800-459-6568 for assistance
4. Contact my **Program Staff at 814-362-6535** for support
5. Emergency Contact Info: _____

   NAME NUMBER

Questions?

Call today at 814-362-6535

AUDIT-C Questionnaire

Patient Name _____ Date of Visit _____

1. How often do you have a drink containing alcohol?
   - ☐ a. Never
   - ☐ b. Monthly or less
   - ☐ c. 2-4 times a month
   - ☐ d. 2-3 times a week
   - ☐ e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?
   - ☐ a. 1 or 2
   - ☐ b. 3 or 4
   - ☐ c. 5 or 6
   - ☐ d. 7 to 9
   - ☐ e. 10 or more

3. How often do you have six or more drinks on one occasion?
   - ☐ a. Never
   - ☐ b. Less than monthly
   - ☐ c. Monthly
   - ☐ d. Weekly
   - ☐ e. Daily or almost daily

Fagerstrom Test for Nicotine Dependence

	PLEASE TICK (✓) ONE BOX FOR EACH QUESTION	
How soon after waking do you smoke your first cigarette?	Within 5 minutes 5-30 minutes 31-60 minutes	☐ 3 ☐ 2 ☐ 1
Do you find it difficult to refrain from smoking in places where it is forbidden? e.g. Church, Library, etc.	Yes No	☐ 1 ☐ 0
Which cigarette would you hate to give up?	The first in the morning Any other	☐ 1 ☐ 0
How many cigarettes a day do you smoke?	10 or less 11 – 20 21 – 30 31 or more	☐ 0 ☐ 1 ☐ 2 ☐ 3
Do you smoke more frequently in the morning?	Yes No	☐ 1 ☐ 0
Do you smoke even if you are sick in bed most of the day?	Yes No	☐ 1 ☐ 0
	Total Score	

SCORE	1- 2 = low dependence 3-4 = low to mod dependence	5 - 7= moderate dependence 8 + = high dependence

Add up the scores from the questionnaire.

Information about scoring the Test is on the next page.

Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? _____

LEC-5 Standard

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war-zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (for example, homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

Adults ONLY

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Children ONLY

Patient Health Questionnaire:

modified

Name: _____ Clinician: _____ Date: _____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the past year have you felt depressed or sad most days, even if you felt okay sometimes?

[ ] Yes [ ] No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life?

[ ] Yes [ ] No

Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

[ ] Yes [ ] No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: Severity score: _____