Florida Youth Suicide Prevention Project Suicide Risk Assessment Form

Client's Name: _____ Date: _____

Home Phone Number: _____ Guardian's Name: _____

E-mail Address: _____ Cell Phone Number: _____

Referral Source: _____ Relation to Youth: _____

DEMOGRAPHICS

A. **Gender**

☐ Male ☐ Female ☐ Transgender Other_____

B. **Age** *(in years)* _____

C. **Ethnicity** ☐ Hispanic ☐ Not Hispanic

☐ Puerto Rican ☐ Cuban ☐ Mexican, Mexican-American or Chicano ☐ Dominican

☐ Central American ☐ South American ☐ Hispanic Origin, not represented in list above: _____

D. **Racial Group(s)** *(Check all that apply)*

☐ Asian/Pacific Islander ☐ White/Caucasian ☐ Black/African American ☐ Native American/Alaskan Native

☐ Hawaiian ☐ American Indian ☐ Don't Know ☐ Other; specify: _____

E. **Languages Fluently Spoken** ☐ English ☐ Spanish ☐ Other; specify: _____

F. **Religious Preference**

☐ None ☐ Don't Know ☐ Catholic ☐ Protestant; specify: _____

☐ Jewish ☐ Buddhist ☐ Islamic ☐ Other; specify: _____

G. **Residence** *(Check all that apply)*

☐ Parent(s) ☐ Sibling(s) ☐ Other Family Members

☐ Lives Alone ☐ Don't Know ☐ Other; specify:_____

H. **Medical Insurance** ☐ Yes ☐ No ☐ Don't Know ☐ Medicaid

SERVICE USAGE & ATTITUDES TOWARD SERVICES

A. **Currently Receiving Therapy/Counseling** ☐ Yes ☐ No ☐ Other_____

B. **Received Therapy/Counseling in the Past**

Prior Outpatient MH/BH Treatment ☐ Yes ☐ No

Prior Inpatient MH/BH Treatment ☐ Yes ☐ No

C. **Hospitalized**

Lifetime ☐ Yes ☐ No

Within the Last 2 years ☐ Yes ☐ No

Related to a Suicide Attempt ☐ Yes #:_____ ☐ No

D. **Barriers to Follow-up Services**

☐ Family Changes ☐ Treatment Demands ☐ Transportation

☐ Financial Issues ☐ Relationship with Provider ☐ Not Needed

PRESENTING CONCERNS

Include symptoms, life stressors, warning signs and possible risk factors leading the client to be at-risk for suicide.

SYMPTOMS & DISTRESS

Results taken from self-screen provided prior to interview with youth

1-4 Minimal	5-9 Mild	10-14 Moderate	15-19 Moderately Severe	20-27 Severe

Comments:

SUICIDE RISK FACTORS

A. **Impulsivity, Careless, Reckless Behavior** *(Check all behaviors that apply)*

☐ Frequent Impulsive Choices ☐ Carelessness in Actions ☐ Reckless Behavior

☐ Lacks Awareness of Other's Feelings ☐ Defiantly Disregards Rules (Fast driving, unprotected sex or stunts)

B. **Emotional Instability and Irritability** *(Check all behaviors that apply)*

☐ Loses Temper Frequently ☐ Easily Irritated ☐ Spiteful/Vindictive Behaviors ☐ Fighting ☐ Lack of Control Over Feelings

C. **Substance Use**

Alcohol Use:

☐ Never ☐ Monthly or Less ☐ 2-4x/Month ☐ 2-3x/Week ☐ 4+/Week

Illicit drugs/other substances:

☐ Never ☐ 1-2 Lifetime ☐ 1-3x/Month ☐ >1x/Week

List **types** of drugs:

D. **Self-Harm/Suicide-Related Behavior** *(Check all behaviors that apply)*

☐ Cutting ☐ Burning ☐ Scratching ☐ Biting ☐ Other Self-Harm without Intent to Die

If yes*:*

Lifetime: ☐ No ☐ Yes ☐ Other_____

Recent (past 2 weeks): ☐ No ☐ Yes ☐ Other_____

E. **Suicidal Ideation -** Thoughts of killing self

Current Ideation: ☐ No ☐ Yes ☐ Other_____

Lifetime Ideation: ☐ No ☐ Yes ☐ Other_____

F. **Suicidal Attempts -** Tried to kill self

Recent Attempts (Past 6 months): ☐ No ☐ Yes # of Attempts_____

Lifetime Attempts: ☐ No ☐ Yes # of Attempts_____

G. **Suicide Plan -** Means and lethality

Presence of Plan (How?): ☐ No ☐ Yes ☐ Other_____

Access to Method: ☐ No ☐ Yes ☐ Other_____

Experience with Method: ☐ No ☐ Yes ☐ Other_____

Method involves *(Check all that apply)*

☐ Firearms ☐ Drugs/Chemicals ☐ Motor Vehicle ☐ Alcohol ☐ Jumping ☐ Strangulation

Other Method *(Please explain):*

H. **Ambivalence and Protective Factors**

Reasons for Dying *(Provide details):*

Reasons for Living *(Provide details):*

List Protective Factors:

SOCIAL SUPPORT & HELP SEEKING

A. **Support Systems** *(Check all that apply)*

☐ Parent(s) ☐ Sibling ☐ Friends ☐ Neighbor ☐ Teacher

☐ Coach/Mentor ☐ Pastor/Minister ☐ Counselor (Guidance) ☐ No One ☐ Other

B. **Seeking Support from Network**

Good friends - can trust and count on	☐ No	☐ Maybe	☐ Yes
Gets along better with adults than peers	☐ No	☐ Maybe	☐ Yes
Usually alone; not with others	☐ No	☐ Maybe	☐ Yes
Generally liked by peers	☐ No	☐ Maybe	☐ Yes
Picked on/bullied by peers	☐ No	☐ Maybe	☐ Yes
Willing to seek support from their network	☐ No	☐ Maybe	☐ Yes

CASE MANAGEMENT ACTIVITIES

Complete after your contact with the client: document the actions you took during and after the interview/phone call to assist this youth.

A. **Emergency Rescue Initiated** ☐ Yes ☐ No ☐ NA

If yes: Rescue was initiated : ☐ Parent's Consent ☐ Youth Assent ☐ Without Client's Consent

B. **Referrals Made** *(Please list all)*

☐ Outpatient MH/BH Services: _____

☐ Other Related Services: _____

☐ No referrals * If no, please provide rationale:_____

C. **Safety Planning Components**

☐ Removal of Method ☐ Self-Care ☐ Call Lifeline Hotline ☐ Recontact Agency

☐ Counseling ☐ Contract to Live ☐ Contact Support Person ☐ No or Safe Use of Alcohol/Drugs

D. Referral Source

☐ Hotline call ☐ Hospital ☐ School Screening (SOS) ☐ Parent/Foster Care

☐ Police/Law Enforcement ☐ Community Agency ☐ Teacher/School Staff ☐ Neighbor/Family Friend

☐ Doctor/Primary Care ☐ Other:_____

Please explain the referral of the client:

By whom:_____

How:_____

When:_____

***30 Day tracking will be completed on _____ (Date) by _____ (Agency).

***This form was submitted by _____ (Counselor/Psychologist Initials) on _____(Date).

Comments: