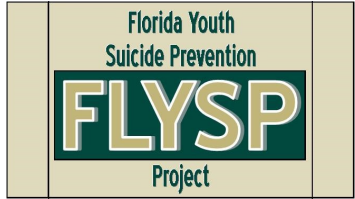




# Florida Youth Suicide Prevention Project Suicide Risk Assessment Form



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: