**Risk Assessment**

**Patient Name** \_

**Session Date** \_

**Date of Birth** \_

Disgnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

**Danger to Self/Suicidal Ideation/Intentions**

**Danger to Others/Homicidal Ideation/Intentions**

**Frequency of occurrence**

Pervasive Daily Weekly lntermittent One Time Only Other \_

**How long does it last** \_

**Intensity of suicidal or homicidal thoughts**

Severe Moderate Mild Comment \_

**Reasons individual would rather die than live** \_

**Detailed plan** \_

**How lethal is the method**

Subliminal Low Moderate High Extremely High

**Access to lethal methods** Yes No ,Possible Other \_

**If firearms, are they being removed from patient access**

Comment \_

Yes No



**Rehearsal behaviors** \_



**Details** \_

**Reasons individual would rather live than die** \_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date

Therapist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Risk Factor Assessment, Rev. 1