# Risk Assessment

**Patient Name** _____ ___ **Date of Birth** _____

**Session Date** _____ _____ Disgnosis: _____

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

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

**Frequency of occurrence**
☐Pervasive ☐Daily ☐Weekly ☐Intermittent ☐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** ☐Yes ☐No
Comment _____

**Steps taken to enact plan** _____

**Rehearsal behaviors** _____

**Obtained access to method** _____

**Details** _____

**Reasons individual would rather live than die** _____

Patient Signature _____Date
_____

Therapist_____