Suicide Risk Assessment

KAISER PERMANENTE®

Patient Label

Name: _____

MRN: _____

Date: _____

To help your provider understand how you've been feeling, please complete the following questions.

Please answer these questions about the past month.	**YES**	**NO**
1. During the past month, have you wished you were dead or wished you could go to sleep and not wake up?		
2. During the past month, have you actually had any thoughts of killing yourself?		
3. During the past month, have you been thinking about how you might kill yourself?		
4. During the past month, have you had some intention of acting on those suicidal thoughts?		
5. During the past month, have you worked out some or all of the details of how to kill yourself?		
6. If YES to #5, do you intend to carry out this plan?		
7. Have you ever done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
8. If YES to #7, 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?		