



**Risk Assessment**

<b>Person's Served Name (First / MI / Last):</b>	<b>Record #:</b>
<b>Organization Name:</b>	

Assess each risk factor and rate from 'No Risk' to 'High' Risk and check each row accordingly								
Risk Factors	✓	No Risk	✓	Low	✓	Moderate	✓	High
<b>Plan to Harm Self</b>	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	No Plan	<input type="checkbox"/>	Vague Plan	<input type="checkbox"/>	Specific Plan
Means Accessibility	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Poor Access	<input type="checkbox"/>	Accessible	<input type="checkbox"/>	Possesses
Lethality Of Means	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Low Lethality	<input type="checkbox"/>	Potentially Lethal	<input type="checkbox"/>	Lethal
Suicidal History	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Ideation/Threat(s)	<input type="checkbox"/>	Gesture(s)	<input type="checkbox"/>	Attempt(s)
Lethality Of Attempts	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Non-Lethal	<input type="checkbox"/>	Injurious	<input type="checkbox"/>	Potentially Lethal
Last Attempt	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	>2 Years	<input type="checkbox"/>	6 Months To 2 Years	<input type="checkbox"/>	Less Than 6 Months
Family History	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Ideation/Threat(s)	<input type="checkbox"/>	Suicide Attempts	<input type="checkbox"/>	Death(s) By Suicide
<b>Plan To Harm Others</b>	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	No Plan	<input type="checkbox"/>	Vague Plan	<input type="checkbox"/>	Specific Plan
Means Accessibility	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Poor Access	<input type="checkbox"/>	Accessible	<input type="checkbox"/>	Possesses
Lethality Of Means	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Low Lethality	<input type="checkbox"/>	Potentially Lethal	<input type="checkbox"/>	Lethal
Assault History	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Ideation/Threat(s)	<input type="checkbox"/>	Single Assault	<input type="checkbox"/>	Multiple Assaults
Lethality Of Assaults	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Minor Injuries	<input type="checkbox"/>	Moderate Injuries	<input type="checkbox"/>	Severe Injuries
Last Assault	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	>2 Years	<input type="checkbox"/>	6 Months To 2 Years	<input type="checkbox"/>	Less Than 6 Months
Family History	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	None	<input type="checkbox"/>	Periodic Violence	<input type="checkbox"/>	Persistent Violence
Arrest Record	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	None	<input type="checkbox"/>	Single Arrest	<input type="checkbox"/>	Multiple Arrests
Physical Abuse Hx	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Minimal Abuse	<input type="checkbox"/>	Moderate Abuse	<input type="checkbox"/>	Severe Abuse
Sexual Abuse Hx	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	No Abuse Reported	<input type="checkbox"/>	Abuse Reported	<input type="checkbox"/>	Severe Abuse
Substance Abuse	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Social Use	<input type="checkbox"/>	AoD Abuse Hx Not Under Influence	<input type="checkbox"/>	AoD Dependent &/Or Under The Influence
<b>Mental Status</b>								
Hallucinations	<input type="checkbox"/>	None reported	<input type="checkbox"/>	Periodic or non-intrusive	<input type="checkbox"/>	Troubling Hallucinations	<input type="checkbox"/>	Command Hallucinations
Judgment and Reality Testing	<input type="checkbox"/>	Intact and functional	<input type="checkbox"/>	Predominantly intact and functional	<input type="checkbox"/>	Periodically impaired	<input type="checkbox"/>	Grossly impaired
Orientation	<input type="checkbox"/>	Hopeful/Immediate and distant future oriented	<input type="checkbox"/>	Predominantly hopeful and future oriented	<input type="checkbox"/>	Minimal hope and sense of efficacy	<input type="checkbox"/>	Hopeless/helpless
Interpersonal interactions	<input type="checkbox"/>	Fully interactive	<input type="checkbox"/>	Intermittent contact with others	<input type="checkbox"/>	Minimal contact with others	<input type="checkbox"/>	Isolated
Impulsivity	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Occasional	<input type="checkbox"/>	Frequent	<input type="checkbox"/>	Persistent
Stress	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Minimal	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Loss	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	>2 Years	<input type="checkbox"/>	6 Months To 2 Years	<input type="checkbox"/>	Less Than 6 Months
Physical Condition	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Financial Stress	<input type="checkbox"/>	None Reported	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Living Arrangements	<input type="checkbox"/>	Safe	<input type="checkbox"/>	With Others	<input type="checkbox"/>	Access To Others	<input type="checkbox"/>	Alone/Isolated
Support From Significant Others	<input type="checkbox"/>	Positive/Helpful	<input type="checkbox"/>	Present/Helpful	<input type="checkbox"/>	Accessible/Somewhat Helpful	<input type="checkbox"/>	Unable/Unwilling To Help
Male Age Suicide	<input type="checkbox"/>	0-12	<input type="checkbox"/>	35-49	<input type="checkbox"/>	13-34	<input type="checkbox"/>	50+
Homicide	<input type="checkbox"/>	1-8	<input type="checkbox"/>	9-12/60+	<input type="checkbox"/>	13-16/30-60	<input type="checkbox"/>	17-30
Female Age Suicide	<input type="checkbox"/>	0-12	<input type="checkbox"/>	39-59	<input type="checkbox"/>	13-38	<input type="checkbox"/>	60+
Homicide	<input type="checkbox"/>	0-12	<input type="checkbox"/>	45+	<input type="checkbox"/>	13- 16/26-44	<input type="checkbox"/>	17-25

**Overall Risk Level:**

<b>None:</b>	<b>Low:</b>	<b>Moderate:</b>	<b>High:</b>
<input type="checkbox"/> Self <input type="checkbox"/> Other	<input type="checkbox"/> Self <input type="checkbox"/> Other	<input type="checkbox"/> Self <input type="checkbox"/> Other	<input type="checkbox"/> Self <input type="checkbox"/> Other

<b>Comments:</b>
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<b>Provider Signature/Credentials:</b>	<b>Date:</b>
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