

SUICIDE RISK ASSESSMENT

Student _____

Date _____

	YES	NO
1. Do you have a suicide plan? Have you ever made suicidal gestures/ threats in the past?		
2. Do you have access to guns, pills, or other lethal means?		
3. Are you having problems communicating with, in conflict with, or feel you are a burden to family or friends?		
4. Have you been having feelings of never-ending problems, not of your own making, not getting any better that you can't resolve?		
5. Do you have any of the following symptoms: insomnia, depression, agitation, anxiety, panic symptoms, eating disturbance?		
6. Have you recently lost a loved one or had a break-up?		
7. Are you being bullied/harassed/or your reputation smeared (Facebook, Instagram, Twitter, Kick, Snapchat)?		
8. Are you having identity conflict such as sexual/gender identity issues?		
9. Have you been given increased responsibilities at home (i.e. younger siblings, impaired/handicapped adult)?		
10. Do you have a history of drug or alcohol abuse?		
11. Have you experienced any serious illness?		
12. Have you talked with your parents/guardians about how you feel? Will they support your getting help?		
13. Do you feel like this is somebody's else's fault? Are you mad at anyone? blaming anyone?		
14. Have you thought about harming anyone at school? or anywhere else?		