

Name: _____

RISK ASSESSMENT (put an X in the box if the answer is yes)

	<u>Current</u>	<u>Past</u>
Have you ever had thoughts of hurting yourself?		
Have you ever had thoughts of committing suicide?		
Have you ever had a plan to commit suicide?		
Have you ever made threats to kill yourself?		
Have you ever made a suicide attempt?		
Have you ever mutilated yourself? (ex. cutting, burning)		
Have you ever had thoughts of harming someone else?		
Have you ever had plans to harm someone else?		
Have you ever attempted to harm someone else?		
Have you ever made threats to harm someone else?		

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling asleep or staying asleep or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or hurting yourself in some way				
If you checked of any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?				

Total PHQ-9 score: _____

Patient Signature: _____

Date: _____

Provider Signature: _____

Date: _____