

Client ID # _____

Date of Administration: _____

SUICIDALITY

CLINICIAN-COMPLETED

1. In the past six months, has the client had suicidal ideation?

- Yes
- No
- Unknown

2. In the past six months, has the client had any suicide attempts?

- Yes
- No
- Unknown

3. If yes, how many times?

4. In the past six months, has the client had non-suicidal self-injurious behavior?

- Yes
- No
- Unknown