Patient Health Screening (PHQ-9)/Columbia-Suicide Severity Rating Scale (Screen Version)

Psychiatric/MH Assessment (Continued)

Patient name	MHN	DOB	Age	Gender

	In The Past Month	
Answer Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts about killing yourself?***		
If **YES** to 2, answer questions 3, 4, 5, and 6. If **NO** to 2, go directly to question 6 ←		
3) ***Have you thought about how you might do this?***		
4) ***Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?***		
5) ***Have you started to work out or worked out the details of how to kill yourself?*** ***Do you intend to carry out this plan?***		
	In the Past 3 Months	
6) ***Have you done any of the following?*** ***Attempted to kill yourself even if ending your life was only part of your motivation*** ***Started to do something to end your life but someone or something stopped you before you actually did anything*** ***Started to do something to end your life but you stopped yourself before you actually did anything*** ***Taken any steps towards making a suicide attempt or preparing to kill yourself*** 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. ***In your entire lifetime, how many times have you done any of these things?***		

Signature/Title _____ Date (m/d/y) ____ /____ /____ Time _____