

**MISSISSIPPI DEPARTMENT OF HUMAN SERVICES  
DIVISION OF YOUTH SERVICES  
INITIAL SUICIDE RISK ASSESSMENT  
XIII.12.F**

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YOUTH:

DATE:

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INTERVIEWER:

TIME:

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**Part I  
Presenting Problem**

Suicidality: Non-Suicidal Self-Injurious Behavior. Suicide Ideation: Suicidal Ideation Denied.

*History: Check all that apply.*

None

Prior Suicidal Behavior

Family History of Suicide

History of Mental Disorder

History of Substance Use Disorder

Family History of  
Mental Disorder

Family History of Substance Use Disorder  
Substance Use Disorder

Prior Hospitalization

Psychotropic Medication

Chronic Physical Illness

Sexual Orientation Issues

Childhood Sexual Abuse

Childhood Physical Abuse

Childhood Emotional Abuse

Target or Witness of Violence

Divorce or Death in Family

History of Eating Disorder

Learning Disability

Cultural Acceptance of Suicide

Other: Describe

Comments:

*Situational Stressors: Check all that apply.*

None.

Abusive Relationship

Target or Witness of Bullying

Recent Death or Loss

Pregnancy

Youth:

Date:

- |   |  |
|---|--|
| <input type="checkbox"/> Recent Move or Change    | <input type="checkbox"/> Removal from Home/Family        |
| <input type="checkbox"/> Lack of Support System   | <input type="checkbox"/> Isolation from Peers            |
| <input type="checkbox"/> Detention or Confinement | <input type="checkbox"/> Staff and Institutional Changes |
| <input type="checkbox"/> SIB Contagion            | <input type="checkbox"/> Suicide Contagion               |
| <input type="checkbox"/> Other: Describe          |  |

Comments:

**Global Signs and Symptoms: Check all that apply.**  None.

- |   |   |
|---|---|
| <input type="checkbox"/> Overeating                       | <input type="checkbox"/> Self Injurious Behavior          |
| <input type="checkbox"/> Insomnia                         | <input type="checkbox"/> Hypersomnia                      |
| <input type="checkbox"/> Agitation or Irritability        | <input type="checkbox"/> Anergia or Fatigue               |
| <input type="checkbox"/> Impaired Concentration or Memory | <input type="checkbox"/> Cognitive Rigidity or Distortion |
| <input type="checkbox"/> Somatic Complaints               | <input type="checkbox"/> Anxiety                          |
| <input type="checkbox"/> Isolation and Withdrawal         | <input type="checkbox"/> Loss of Interest in Activities   |
| <input type="checkbox"/> Low Self Esteem                  | <input type="checkbox"/> Hopelessness                     |
| <input type="checkbox"/> Neglecting Appearance            | <input type="checkbox"/> Neglecting Hygiene               |
| <input type="checkbox"/> Impulsivity or Risk Taking       | <input type="checkbox"/> Aggression or Violence           |
| <input type="checkbox"/> Substance Use or Intoxication    | <input type="checkbox"/> Hypersexual Behavior             |

Other: Describe

Comments:

Youth:

Date:

***Specific Signs and Symptoms: Check all that apply.***

None.

- |   |  |
|---|--|
| <input type="checkbox"/> Preoccupation with Death | <input type="checkbox"/> Discarding Personal Items |
| <input type="checkbox"/> Writing About Death      | <input type="checkbox"/> Writing About Suicide     |
| <input type="checkbox"/> Suicidal Thought         | <input type="checkbox"/> Suicidal Verbalization    |
| <input type="checkbox"/> Suicidal Gesture         | <input type="checkbox"/> Suicide Attempt           |
| <input type="checkbox"/> Other: Describe          |  |

Comments:

### **Interview Schedule**

1. How many times have you tried to commit suicide?

(If only one attempt, proceed. If more than one attempt, then preface comments with “Let’s begin with the last time you tried, ...” and complete all questions in this section. Then, repeat all of the questions asking about each previous suicide attempt until all suicide attempts have been covered.)

2. When did this happen?

3. What did you do to try to kill yourself?

4. Where you injured? If so, did you receive medical attention? (Specify where and nature of attention.)

5. Why did you try to kill yourself?

6. What was your mood at the time?

7. Who knows that you tried to kill yourself?

8. The suicide attempt obviously did not succeed; how do you feel about the fact that you did not die?

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9. How is it that you did not die? (If rescued, get the name and relationship of the rescuer and whether the rescue was coincidental or foreseeable.)

10. Did you have any counseling with a professional after the attempt? (If so, list the details.)

11. Which (if any) of the following preparations for death did you make?

Researched a method  Bid farewell to significant others

Acquired the means  Wrote a suicide note

Told someone about suicidal intentions  Made funeral plans

Gave away valued possessions  Other:

## **Part II Suicide Ideation**

The following questions relate to what the youth is thinking and should be asked if the person is now, or has ever considered, committing suicide.

12. When did you last feel suicidal?

13. Sometime when people feel like that they have a vague idea of wanting to die; sometimes they have very specific ideas about dying. How specific were your thoughts?

14. What was happening in your life that made you feel like that?

15. How often do you feel like that?

16. When you feel like that, how long do these thoughts last?

17. Some people who get thoughts like that are troubled or frightened by them. Others don't find these thoughts to be particularly upsetting. How do such thoughts make you feel?

18. Do you feel that you can control these thoughts?

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### **Part III**

## **General Questions**

The following questions relate to how a person views life and would handle stressful or life-threatening situations.

19. If you found your life threatened by someone or something today, would you make efforts to save yourself?

20. If you had some easy way of killing yourself, like a gun in your room, would you consider using it?

21. Do you have any self-inflicted wounds or scars (if so, list the details)? Have you ever harmed yourself on purpose without intending to die?

22. Do you believe in a god or an afterlife? (If someone were someone to commit suicide what do you believe might happen to them after death?)

23. Most people have reasons for wanting to live. What are yours?

24. If something was bothering you, and you wanted to talk or wanted some emotional support, is there someone to whom you would go? Who?

25. Have there been any recent upsets or changes in your relationships with your family or friends?

26. Have you known anyone who has committed suicide? (If yes, record the details.)

27. Is there some special anniversary or date coming up that makes you feel uncomfortable?

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28. How are you feeling today or, more specifically, what emotions are you feeling today?

29. I have a list of emotions that some people have told me they feel when they come to this facility. I'd like to read this list to you and I'd like you to tell me whether or not you're feeling any of them by answering "yes" or "no".

(Place an "X" to indicate feelings reported by the student.)

- |                                     |                                      |  |
|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Upset      | <input type="checkbox"/> Mad         | <input type="checkbox"/> Furious       |
| <input type="checkbox"/> Sad        | <input type="checkbox"/> Depressed   | <input type="checkbox"/> Troubled      |
| <input type="checkbox"/> Anxious    | <input type="checkbox"/> Scared      | <input type="checkbox"/> Terrified     |
| <input type="checkbox"/> Lonely     | <input type="checkbox"/> Guilty      | <input type="checkbox"/> Misunderstood |
| <input type="checkbox"/> Distracted | <input type="checkbox"/> Bored       | <input type="checkbox"/> Confused      |
| <input type="checkbox"/> Distressed | <input type="checkbox"/> Shocked     | <input type="checkbox"/> Ashamed       |
| <input type="checkbox"/> Insulted   | <input type="checkbox"/> Embarrassed | <input type="checkbox"/> Calm          |
| <input type="checkbox"/> Happy      | <input type="checkbox"/> Relaxed     |  |

Case Conceptualization:

\_\_\_\_\_  
Signature of Interviewer

Date\_\_\_\_\_