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

**Psychiatric/MH Assessment (Continued)**

<table>
<thead>
<tr>
<th>Patient name</th>
<th>MHN</th>
<th>DOB</th>
<th>Age</th>
<th>Gender</th>
<th>In The Past Month</th>
</tr>
</thead>
<tbody>
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<td></td>
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<td></td>
<td>YES</td>
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</table>

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?

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 ________

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