

# HEALING MINDS

## C-SSRS — Suicide Risk Screening Tool

Patient Name:

Date:

**1. Have you wished you were dead or wished you could go to sleep and not wake up?**

Yes                    No

**2. Have you had any actual thoughts of killing yourself?**

Yes                    No

**3. Have you been thinking about how you might do this?**

Yes                    No

**4. Have you had these thoughts and had some intention of acting on them?**

Yes                    No

**5. Have you started to work out or worked out the details of how to kill yourself?**

Yes                    No

**6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?**

Yes                    No

**7. Clinical Risk Level (Provider selects):**

No Risk

Low Risk

Moderate Risk

High Risk

**8. Provider Notes / Safety Plan:**