Suicide/Self-Harm History

Name:

Date (mm/dd/yyyy)

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Have you ever tried to harm or kill yourself?

Yes

No

If you answered "no," skip the rest of this page.

Was your intent to die?

Yes

No

Elaborate below, if desired:

How many times in your life has this occurred?

Most Severe Episode

Please describe your most severe episode including date, method, and consequences:

Month Year Method Other Method

Consequences Other Consequences

Please go to next page...

Most Recent Episode

Please describe your most severe episode including date, method, and consequences:

Month Year Method Other Method

Consequences Other Consequences

Please return this form to the office one day prior to your appointment or email it to hwanderson@q.com. Or, you may FAX it to 970-205-9462. If you choose to email it you can go to Sendinc at www.sendinc.com and mail it securely. You will need to set up an account, which is free. Thank you.