Client At Risk Assessment

Name/File number:_____ **Date**:_____

Counsellor:_____ **Time**:_____

If the client's score on the **Initial** or **Closing Client Questionnaire-PHQ-9** is **15 or greater** OR client has endorsed anything other than **not at all** on Q #9, the **counsellor must complete this form**. It must also be completed any time the counsellor assesses the client to be at risk regardless of the information on the Client Questionnaires.

	LOWER RISK	MODERATE RISK	HIGH RISK
RISK TO SELF	Occasional private thoughts or feelings in relation to; ☐ Suicide or self-harm ☐ Hopelessness	Frequent or persistent private thoughts or feelings in relation to; ☐ Suicide or self-harm ☐ Hopelessness A history of; ☐ Any previous attempts at suicide or self harm Planning; ☐ Vague plans ☐ Non-specific threats or promises	Voiced specific thoughts or feelings in relation to; ☐ Suicide or self harm ☐ Hopelessness A recent history of; ☐ Multiple attempts at suicide or self harm Planning; ☐ Detailed plans ☐ Specific threats or promises
RISK TO OTHER	Occasional private thoughts or feelings in relation to; ☐ Harm ☐ Intense anger	Frequent or persistent private thoughts or feelings in relation to; ☐ Harm or death ☐ Intense anger A history of; ☐ Previous harm Planning; ☐ Vague plans ☐ Non-specific threats, promises or assertions	Voiced specific thoughts or feelings in relation to; ☐ Harm ☐ Expressed anger A recent history of; ☐ Multiple attempts at harm Planning; ☐ Detailed plans ☐ Specific threats, promises or assertions
RISK FROM OTHER	☐ Worries or fears of an attack in the absence of a previous history of threats or violence	☐ Worries or fears of an attack with a previous history of threats of violence or actual violence ☐ Non-specific threats, assertions or promises	☐ Specific threats, promises or assertions A recent history of; ☐ Attempts at harm or actual harm

RISK MULTIPLIERS

MEDICAL
- ☐ Alcohol or drugs
- ☐ Changes in medications
- ☐ Depression

FINANCIAL
- ☐ Loss of employment
- ☐ Underemployment
- ☐ Debt

SOCIAL/LEGAL
- ☐ Lack of social support
- ☐ Physical isolation
- ☐ Emotional isolation
- ☐ Relationship/family
- ☐ Legal

COGNITIVE
- ☐ Attitudes that indicate the objectification of persons

Please turnover ➔

Client At Risk Assessment

Client Phone No.:_____

Client Physical Address:_____

_____

Age Category:

☐ Child/Youth <19 years
☐ Adult>19 years

SITUATION:		
RISK TO SELF ☐ High ☐ Moderate ☐ Low	**RISK TO OTHER** ☐ High ☐ Moderate ☐ Low	**RISK FROM OTHER** ☐ High ☐ Moderate ☐ Low

MULTIPLIER(S):_____

To do	Done	SAFETY PLAN CHECKLIST	Counsellor	Client	Other
☐	☐	Parent/guardian of an at risk child or family member/ friend of an at risk adult contacted	☐	☐	☐
☐	☐	Supervisor contacted	☐	☐	☐
☐	☐	Family physician contacted (encourage parents or adult client to do this)	☐	☐	☐
☐	☐	Mental Health contacted by phone	☐	☐	☐
☐	☐	Hospital contacted by phone	☐	☐	☐
☐	☐	Crisis Line contacted by phone	☐	☐	☐
☐	☐	RCMP/ambulance contacted, phone 911	☐	☐	☐
☐	☐	☐ Contact or conference with; ☐ Parents ☐ Family physician ☐ Mental Health therapist ☐ Harm means removed from home (e.g. guns, pills, etc.) ☐ Describe:_____	☐	☐	☐
☐	☐	24 hour supervision available. Supervisor:_____ Phone #:_____	☐	☐	☐
☐	☐	Supports/resources identified and phone numbers given. Resources: _____	☐	☐	☐
☐	☐	Suicide/safety commitment or contract agreed to.	☐	☐	☐
☐	☐	Next contact time set. Date:_____	☐	☐	☐