<u>School Screening Form</u>

(To be completed by the school counselor)

Student Name:________________________ Age:_____________________

Grade:_______________________________Date of Birth:_______________

The above mentioned student is being screened for:

_____Suicidal Thoughts/Ideation/Attempts or

_____Homicidal Thoughts/Ideation/Attempts/Acts

Check all that apply:

- ☐ Recurrent Thoughts of Death
- ☐ Preoccupation with Death
- ☐ Suicidal/Homicidal Ideation without a plan
- ☐ Suicidal/Homicidal Ideation with a plan
- ☐ Passive death wishes
- ☐ recent suicide attempt
- ☐ history of suicide attempt
- ☐ recent attempt to injure others
- ☐ family history of depression or violence
- ☐ depression
- ☐ violence
- ☐ feeling helpless or hopeless
- ☐ painful life events:___________________
- ☐ rejection experiences
- ☐ broken relationships
- ☐ social withdrawal
- ☐ feelings of alienation
- ☐ lethargic or apathetic
- ☐ self-destructive behavior
- ☐ potentially dangerous behavior:__________________
- ☐ drug use
- ☐ alcohol use
- ☐ disappearing from a group
- ☐ recent family losses (divorce, death, loss of job)
- ☐ change in personality (sad, withdrawn, irritable, anxious, tired)
- ☐ change in behavior (can't concentrate)
- ☐ change in sleep patterns
- ☐ change in eating habits
- ☐ menstrual abnormalities
- ☐ fear of losing control (going crazy)
- ☐ low self esteem (shame, guilt, self-hatred)
- ☐ making out wills
- ☐ giving away things