Mental Health Risk Assessment Checklist

Educational worksheet for licensed mental health clinicians. Use it to structure screening, factor review, formulation, action, documentation, and follow-up. It does not score risk, decide disposition, or replace clinical judgment, supervision, counsel, or your emergency protocol.

1. Context and domains to cover

- ☐ Client identifiers / date / setting (in person, telehealth, collateral)
- ☐ Domains reviewed: suicide · self-harm · harm to others · neglect/abuse · functional decompensation
- ☐ Presenting context and why risk is being assessed now
- ☐ Limits of confidentiality reviewed when clinically indicated

2. Tool selection (name what you used)

- ☐ Validated suicide screen used (e.g. C-SSRS) — instrument name and version
- ☐ SAFE-T or equivalent clinical framework used for structure
- ☐ Other measures used (PHQ-9 item 9, CSSRS lifetime, substance screens)
- ☐ Why this tool fit this client and setting (or why a full instrument was deferred)
- ☐ Any observational limits (audio-only telehealth, interpreter, incomplete history)

3. Static, dynamic, and protective factors

- ☐ Static / historical factors listed (prior attempts, diagnoses, trauma, access history)
- ☐ Dynamic / modifiable factors listed (ideation, plan, intent, means, substances, stressors)
- ☐ Warning signs observed this encounter
- ☐ Protective factors documented without treating them as a risk offset
- ☐ Lethal means access discussed and recorded (firearms, meds, other)

4. Clinical formulation (your judgment — not a form score)

- ☐ Risk level stated in clinical language (acute / chronic dimensions as applicable)
- ☐ Rationale names elevating and mitigating factors
- ☐ Domains without elevated concern explicitly documented (not left blank)
- ☐ Differentials considered if presentation is ambiguous

5. Action, disposition, and continuity

- ☐ Interventions matched to the formulation (means counseling, safety plan, supports)
- ☐ Level-of-care / disposition decision and who was notified
- ☐ Safety plan format used (e.g. Stanley-Brown) if indicated
- ☐ Mandatory reporting considered; action taken or rationale for not reporting
- ☐ Supervision or consultation obtained / planned when indicated
- ☐ Reassessment timing and earlier-review triggers named
- ☐ Next contact and continuity plan if no-show, waitlist, or transfer is likely

6. Chart quality check before sign-off

- ☐ Screening language matches the instrument used
- ☐ Formulation and disposition are consistent with each other
- ☐ Client quotes used where they strengthen the record
- ☐ No automated or software-generated risk label left unsigned
- ☐ Clinician name, credentials, date/time, and signature complete