

**Department of Mental Health
Community Risk Identification Tool**

IDENTIFYING INFORMATION

Client Name:		
DMH Area of Tie:		
Record Number:		
Date of Birth:	Current Age:	Gender:
Guardian/Legally Authorized Representative:		
Name of Person Completing This Tool:		
Date of Completion of This Tool:		
Additional State Agency Involvement: (DCF, DDS, DYS, Other)		

Recorded Diagnoses:

Please complete the following items by circling the best response that describes the individual's HISTORY. Do not leave questions unanswered. Circle Unknown where applicable. All answers for persons under age 18 should be provided according to age/developmental norms.

1) History of suicidal or other self-injurious behavior (i.e., substantial risk of harm to self)			
a) History of suicide attempts	Yes	No	Unknown
If yes, number of attempts: Mo/Yr of most recent attempt: Mo/Yr of first attempt:			
b) History of medical hospitalization due to suicide attempt	Yes	No	Unknown
c) History of psychiatric hospitalization due to suicide attempts	Yes	No	Unknown
d) Family history of suicide or suicide attempts	Yes	No	Unknown
e) History of other self-injurious behavior (e.g., cutting, head banging, burning self) If yes, describe	Yes	No	Unknown
2) Physical violence towards others and criminal historical factors:			
a) History of behavior resulting in the injury of another person	Yes	No	Unknown
b) History of behavior that could have resulted in the injury of another person (e.g., Operating a motor vehicle, under the influence or to endanger, armed robbery, deliberate other aggressive behavior, etc.) If Yes, describe	Yes	No	Unknown
c) History of threats toward others If known, please describe and provide date of most recent threats _____ _____	Yes	No	Unknown
d) History of weapon use If yes, type of weapon i. Gun ii. Knife	Yes	No	Unknown
	Yes	No	Unknown
	Yes	No	Unknown

iii. Other (describe): _____	Yes	No	Unknown
iv. Unknown	Yes	No	Unknown
e) History of arrest for a violent crime If yes, please describe: If yes, did the arrest result in a conviction, an adjudication of Incompetent to Stand Trial or Not Guilty by Reason of Insanity for any of the following charges?	Yes	No	Unknown
v. Murder	Yes	No	Unknown
vi. Manslaughter	Yes	No	Unknown
vii. Kidnapping	Yes	No	Unknown
viii. Rape	Yes	No	Unknown
ix. Mayhem	Yes	No	Unknown
x. Assault & Battery with Intent to Murder	Yes	No	Unknown
xi. Assault & Battery with Intent to Rape	Yes	No	Unknown
xii. Assault with Intent to Murder	Yes	No	Unknown
xiii. Assault with Intent to Rape	Yes	No	Unknown
xiv. Indecent Assault & Battery on child (under 14)	Yes	No	Unknown
xv. Arson	Yes	No	Unknown
xvi. Stalking	Yes	No	Unknown
xvii. SORB Level III	Yes	No	Unknown
f) History of commitment to BSH for treatment	Yes	No	Unknown
g) History of threats/aggression toward public figures	Yes	No	Unknown
3) History of non-violent but unacceptable behavior that has significant social consequences (e.g., victimizing vulnerable individuals, bullying, sexual exploitation, etc.) If yes, please describe: _____	Yes	No	Unknown
4) History of sexual violence towards others			
a) History of sexual violence/unlawful sexual activity towards others If yes, please describe: _____	Yes	No	Unknown
b) Historical sexual violence against: (check all that apply) () Family member () Stranger () Male () Female () Children under age 18 Specify age if known: _____	Yes	No	Unknown
c) History of arrest for a sexual crime If yes, please describe: _____	Yes	No	Unknown
d) History of other problematic sexual behavior If yes, please describe: _____	Yes	No	Unknown
e) SORB Involvement If yes, Level: _____	Yes	No	Unknown
5) Risk of harm due to inability to care for self (as developmentally appropriate) based on history of			
a) Wandering and/or getting lost	Yes	No	Unknown
b) Endangering self by dressing inappropriately for cold or hot weather	Yes	No	Unknown
c) History of heat stroke, frostbite or other weather-related problem	Yes	No	Unknown
d) Poor judgment may provoke others to assault client	Yes	No	Unknown
e) Inability to care for personal hygiene/ADL needs leading to life (health) endangering self-neglect	Yes	No	Unknown
f) History of failure to care for serious medical condition If yes, please describe: _____	Yes	No	Unknown
g) Other (e.g. history of sexual and/or physical victimization) If yes, please describe: _____	Yes	No	Unknown

6) History of or potential for intended or accidental fire setting or fire play If yes, please describe: _____	Yes	No	Unknown
7) Capacity to make treatment decisions			
a) Current Rogers guardianship	Yes	No	Unknown
b) History of Rogers guardianship	Yes	No	Unknown
c) Current Guardianship of the person (i.e., plenary guardianship)	Yes	No	Unknown
d) Current medical guardianship	Yes	No	Unknown
e) History of medical or plenary guardianship	Yes	No	Unknown
8) Ability to carry out functional roles			
a) Currently unable to live independently	Yes	No	Unknown
b) History of inability to live independently	Yes	No	Unknown
c) History of employment instability	Yes	No	Unknown
9) Ability to Self-administer medications			
a) Cannot safely self-administer medications	Yes	No	Unknown
b) History of inability to safely self-administer medications	Yes	No	Unknown
c) History of abusing prescription medications	Yes	No	Unknown
10) Neurological condition(s):			
b) History of head injury leading to loss of consciousness or hospitalization	Yes	No	Unknown
c) History of neurological illness:	Yes	No	Unknown
i. Seizure disorder/Epilepsy	Yes	No	Unknown
ii. Stroke	Yes	No	Unknown
iii. Dementia or other cognitive challenges	Yes	No	Unknown
iv. Huntington's Disease	Yes	No	Unknown
v. Multiple Sclerosis	Yes	No	Unknown
vi. Other (specify): _____	Yes	No	Unknown
d) Diagnosis or presence of Intellectual Disability	Yes	No	Unknown
e) Diagnosis or presence of Autism Spectrum conditions or PDD	Yes	No	Unknown
f) Current or historical functional impairment related to a neurological condition If yes, please describe: _____	Yes	No	Unknown
g) Ever evaluated or followed by neurology or neurosurgery?	Yes	No	Unknown
h) Presence of medication-related serious side effects (e.g. tardive dyskinesia or other movement disorder, acute dramatic change in mental state, etc.) If yes, please describe: _____	Yes	No	Unknown
11) Medical condition(s):			
a) History of or active medical diseases	Yes	No	Unknown
i. Respiratory problems, COPD, asthma	Yes	No	Unknown
ii. Heart Disease – MI, CHF, arrhythmias	Yes	No	Unknown
iii. GI – ulcers, inflammatory bowel disease	Yes	No	Unknown
iv. Metabolic syndrome, diabetes	Yes	No	Unknown
v. Malignancy/cancer	Yes	No	Unknown
vi. TB	Yes	No	Unknown
If yes, documented treatment received?	Yes	No	Unknown
vii. Other infectious diseases?	Yes	No	Unknown
viii. Medical problems related to alcohol/substance use (e.g., liver problems)	Yes	No	Unknown
b) Is the individual receiving and following through with recommended medical care currently?	Yes	No	Unknown
12) Alcohol/Substance Use			
a) History of problems associated with alcohol/substance use?	Yes	No	Unknown

Please briefly specify type of substance(s): _____ _____			
b) History of detoxification or rehabilitation program involvement for alcohol/substance use	Yes	No	Unknown
c) History of commitment pursuant to M.G.L. c. 123, s.35 i. If yes, how many times? _____	Yes	No	Unknown
13) Psychiatric treatment non-adherence			
a) History of discontinuing recommended psychiatric treatment If yes, please describe: _____ _____	Yes	No	Unknown
14) Criminal or Juvenile justice involvement and supervision			
a) Current criminal or juvenile justice supervision with DYS/probation/parole	Yes	No	Unknown
b) History of Criminal Court involvement	Yes	No	Unknown
c) History of Juvenile Court involvement	Yes	No	Unknown
d) History of leaving a correctional or DYS setting without authorization If yes, please describe: _____ _____	Yes	No	Unknown
e) History of noncompliance with probation/parole/court appearances	Yes	No	Unknown
15) Other risk areas Please specify if this client has any other factor that is considered to place others or himself/herself at significant risk of harm (e.g., self-harming behaviors, unwanted repeated contact of others, animal torture, gang involvement, obsessive focus of interest on particular individual, serious self-harm, etc.): 			
16) Current Psychosocial Stressors (e.g., environmental, familial, situational, financial, peer related) 			
17) Areas of particular strength that may mitigate some of the risk history (e.g., positive social supports, positive alliances with providers, vocational skills, interpersonal strengths, educational goals or accomplishments, hopefulness, adherence to treatment if recommended, periods of sobriety, etc.) : 			

*It is recognized that all individuals have strengths, and individuals may have some aspect of their background that has included risk to self or others. This tool is designed as a brief screening tool to identify known historical and other clinical risk factors that can contribute to compromised personal and public safety. Strengths of the individual and factors that mitigate risks and improve safety are noted, but are to be delineated further with ongoing work with the client.

This tool is not meant as a full clinical assessment and need not be completed by a clinician. Items checked 'yes' and 'unknown' are identified as a guide for areas of further inquiry by clinical service providers to enhance treatment and support services and to help guide work with the client to mitigate any identified risk areas.