Suicide Behaviors Questionnaire (SBQ-R)

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1. Please enter the client's information:

Client First Name: _____ Client Last Name: _____ Client DOB: _____

Instructions: Please mark the number beside the statement or phrase that best applies to you.

2. Have you ever thought about or attempted to kill yourself? Please pick one:

- 1. Never
- 2. It was just a brief passing thought
- 3a. I have had a plan at least once to kill myself but did not try to do it
- 3b. I had a plan at least once to kill myself and really wanted to die
- 4a. I have attempted to kill myself, but did not want to die
- 4b. I have attempted to kill myself and really hoped to die

3. How often have you thought about killing yourself in the past year?

- 1. Never
- 2. Rarely (1 time)
- 3. Sometimes (2 times)
- 4. Often (3-4 times)
- 5. Very often (5 or more times)

4. Have you ever told someone that you were going to commit suicide, or that you might do it?

- 1. No
- 2a. Yes, at one time, but did not really want to die
- 2b. Yes, at one time, and really wanted to die
- 3a. Yes, more than once, but did not want to do it
- 3b. Yes, more than once, and really wanted to do it

5. How likely is it that you will attempt suicide someday?

- 0. Never
- 1. No chance at all
- 2. Rather Unlikely
- 3. Unlikely
- 4. Likely
- 5. Rather unlikely
- 6. Very likely

Scoring and Copyright (Office Use Only):

Overview:

Due to the wording of the four SBQ-R items, a broad range of information is obtained in a very brief administration. Responses can be used to identify at-risk Individuals and specific behaviors.

Scoring:

Each answer chosen has a number beside it, such as 1, or 2, or 2a or 2b etc. To add up the total score, simply add up the 4 numbers beside each answers.

For Example

(Question 1 = **3**a) + (Question 2 = **2**) + (Question 3 = **2**b) + (Question 4 = **3**)

Total score *3+2+2+3* = **10**

Interpreting Scores:

- **For adults in the general population:**
  - People with a score of **3-6 reflects a negative screening** for suicide risk
  - People with a score of 7 or greater are considered at risk of suicide
- **For adults in a psychiatric inpatient program**: People with a score of **8 or greater** are considered at risk of suicide

Developers:

Osman A, Bagge CL, Gutierrez PM, Konick LC, Kopper BA, Barrios FX. The suicidal behaviors questionnaire revised (SBQ-R): Validation with clinical and nonclinical samples. Assessment. 2001; 8(4):443-454.