Self-Harm (NSSI) Assessment Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A self-harm (NSSI) assessment records how a clinician evaluated non-suicidal self-injury: how it surfaced, its history and severity, the suicide risk screen with the intent determination, its function, and the formulation with the response. No statute prescribes the layout; the standard is a documented process that shows the intent determination being assessed, never assumed.

Reason for assessment & context what prompted it
Do: record the trigger (disclosure, screen, collateral report, medical finding) plus stressors, course, substance use.
Pitfall: findings with no visible trigger read as template output, not evaluation.

Self-injury history & characterization comparable next time
Do: onset, most recent episode, frequency band, method category, stability, and medical severity as care required.
Pitfall: "superficial" as a conclusion with no severity assessment behind it reads as dismissal.

Suicide screen & intent determination the load-bearing section
Do: ask directly; record ideation, plan, intent, behavior history, the client's account, and the basis for "non-suicidal".
Pitfall: intent inferred from the injury itself; the distinction is a finding, never a default.

Function, antecedents & triggers what it regulates
Do: record the function in the client's terms (intrapersonal or social), where urges rise, what has interrupted it.
Pitfall: no function documented means the treatment plan cannot target it.

Risk & protective factors this client, today
Do: separate acute from chronic, include the self-injury history itself, keep protective factors current.
Pitfall: boilerplate copied forward unchanged cuts both ways in a later review.

Risk formulation narrative first
Do: connect findings to the response, say how suicide risk stays under surveillance, add the level your setting requires.
Pitfall: a tier with no reasoning, or prediction language like "will not escalate".

Interventions & response plan completed, not intended
Do: record skills rehearsed, the response plan completed with copy given, access-reduction steps, supports with consent.
Pitfall: "will develop coping strategies" documents a plan to intervene, not an intervention.

Diagnosis & coding R45.88 is a symptom code
Do: code the underlying disorder first; add R45.88 alongside it where your setting codes the behavior.
Pitfall: R45.88 standing alone as the principal diagnosis misstates the picture.

Disposition, follow-up & reassessment dated and tracked
Do: level of care, dated next contact, escalation instructions, consultation, and the reassessment cadence.
Pitfall: "will monitor" with no date; a behavior assessed once and dropped reads as abandoned.

Before you sign

- [ ] Intent determination shown with its basis
- [ ] Suicide screen documented, result written
- [ ] Recency, frequency band, severity recorded
- [ ] Function recorded; the plan targets it
- [ ] Interventions completed, dated, copy given
- [ ] Reassessment cadence set, screen included
- [ ] Signed with credentials, dated promptly

Drafting with AI

Capture 30 seconds of bullets after the session: trigger, history band, screen result and intent basis, function, factors, formulation, interventions, next contact.

"Draft a self-harm (NSSI) assessment note from these bullets for an outpatient client who disclosed recurrent self-injury, suicide screen negative: …"

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

300 to 800 words	10 to 25 min by hand	Disclosure · screen · follow-up	Care team · boards · reviewers
typical length	clinical team estimate	when completed	who reads it

Full guide, sample note, and compliance notes: **bastiongpt.com/template/self-harm-assessment**

Self-Harm (NSSI) Assessment Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Client (initials): Date: Setting: ☐ office ☐ telehealth ☐ school/campus ☐ other

Prompted by: ☐ disclosure in session ☐ screening result ☐ collateral report ☐ medical finding

Context & precipitants

Presenting problems, current stressors, substance use

Self-injury history & characterization

Onset · most recent episode · frequency band · method category · stable or changing · medical severity / care required

Suicide risk screen & intent determination

Ideation, plan, intent, behavior history · screen used and result · determination with its basis

Function, antecedents & triggers

What the behavior regulates · settings where urges rise · what has interrupted it before

Risk factors

Acute / chronic, incl. the behavior itself

Protective factors

Specific to this client, today

Risk formulation

Narrative reasoning connecting findings to the response · add the level your setting requires

Interventions & response plan

Skills rehearsed · response plan completed, copy given · access-reduction steps · supports w/ consent · crisis resources

Diagnosis & coding

Underlying diagnosis first · R45.88 as an added symptom code

Disposition, follow-up & reassessment

Level of care · dated next contact · escalation instructions · consultation · reassessment cadence for behavior and screen

Clinician signature / credentials: Date signed: