Behavioral Daily Assessment

Date: _____

Name: _____

Please answer the following questions about your experiences in the past 24 hours.

1. Have you had any thoughts or urges to harm or hurt yourself? ☐ Yes ☐ No
   a. Have you tried, planned, or actually harmed yourself? ☐ Yes* ☐ No
      **If Yes, please explain in more detail*: _____

2. Have you had any thoughts or urges to hurt someone else? ☐ Yes ☐ No
   a. Have you tried, planned, or actually hurt someone else? ☐ Yes* ☐ No
      **If Yes, please explain in more detail*: _____

3. Rate the quality of your sleep from 1 (very poor) to 5 (very good): _____

4. Rate how hungry you felt from 1 (not at all hungry) to 5 (very hungry): _____

5. Have you felt any side effects from medicine?
   _____

6. Please rate (*0-10*) how strong each of the following emotions/feelings have been in the past 24 hours.
   0 = none, 2=a bit, 4=somewhat, 6=rather strong, 8=very strong, 10 = extremely strong

Sad	Angry	Anxious	Happy

7. What skills have you used in the past 24 hours? Please circle all that apply.

- ☐ Identified warning signs
- ☐ Distracted myself
- ☐ Asked for support/help
- ☐ Problem solved
- ☐ Self-soothe/Sensory
- ☐ MEDS (Medication, Eating, Daily Activity, Sleep)
- ☐ ACCEPTS (Activities, Contributing, Comparisons, Emotions, Pushing Away, Thoughts, Sensations)
- ☐ TIPP (Temperature, Intensity, Paced Breathing, Progressive Muscle Relaxation)
- ☐ Other: *(write below)*