

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ Age: _____ Sex: _____ Date: _____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

			None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
During the past TWO (2) WEEKS , how much (or how often) have you...								
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	2.	Worried about your health or about getting sick?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
IV.	5.	Had less fun doing things than you used to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	6.	Felt sad or depressed for several hours?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	8.	Felt angry or lost your temper?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	10.	Slept less than usual but still had a lot of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
VIII.	11.	Felt nervous, anxious, or scared?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	12.	Not been able to stop worrying?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
In the past TWO (2) WEEKS , have you...								
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	<input type="radio"/> Yes		<input type="radio"/> No			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	<input type="radio"/> Yes		<input type="radio"/> No			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	<input type="radio"/> Yes		<input type="radio"/> No			
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	<input type="radio"/> Yes		<input type="radio"/> No			
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	<input type="radio"/> Yes		<input type="radio"/> No			
	25.	Have you EVER tried to kill yourself?	<input type="radio"/> Yes		<input type="radio"/> No			