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

Name	::	Age: Sex: \square Male	☐ Fem	iale	Dat	e:		
		ns: The questions below ask about things that might have bothered you. For earlier much (or how often) you have been bothered by each problem during the				number th	nat best	
	Dui	ring the past TWO (2) WEEKS, how much (or how often) have you	None Not at all	Slight Rare, less than a day or two)	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
l.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	- 0	1	2	3.	4	
11.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
111.	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?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. &	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
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?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
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?	0	1	2	3	4	
	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?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
	In th	ne past TWO (2) WEEKS, have you			THE PARTY OF THE P		organization de la companie de la co	ene pena epetito tako dila
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes					

21. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?

methamphetamine (like speed)?

steroids)?

suicide?

XII.

24.

Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), 22. hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or

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 In the last 2 weeks, have you thought about killing yourself or committing □ Yes □ No 25. Have you EVER tried to kill yourself? □ Yes □ No Copyright © 2013 American Psychiatric Association. All Rights Reserved. This material can be reproduced without permission by researchers and by clinicians for use with their patients.

Yes

□ Yes

☐ Yes

No

□ No

□ No