DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ Age: ___ Completed by_____ Date: _____

	For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the past TWO (2) WEEKS.	None	Few days	Some days	Most days	Severe daily
I	1. Complained of stomach aches, headaches, or other aches and pains?	0	1	2	3	4
	2. Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4
II	3. Had problems sleeping; trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4
III	4. Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4
IV	5. Had less fun doing things than he/she used to?	0	1	2	3	4
	6. Seemed sad or depressed for several hours?	0	1	2	3	4
V VI	7. Seemed more irritated or easily annoyed than usual?	0	1	2	3	4
	8. Seemed angry or lost his/her temper?	0	1	2	3	4
VII	9. Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4
	10. Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4
VII I	11. Said he/she felt nervous, anxious, or scared?	0	1	2	3	4
	12. Not been able to stop worrying?	0	1	2	3	4
	13. Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4
IX	14. Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4
	15. Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4
X	16. Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4
	17. Said he/she 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. Seemed to worry a lot about things he/she touched/being dirty/germs/being poisoned?	0	1	2	3	4
	19. Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4
XI	20. Had an alcoholic beverage (beer, wine, liquor, etc.)? Yes No Don't Know	0	1	2	3	4
	21. Smoked a cigarette/cigar/pipe/vape/used snuff/chew? Yes No Don't Know	0	1	2	3	4
	22. Used marijuana, cocaine/crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants (like glue), or methamphetamine (like speed)? Yes No Don't Know	0	1	2	3	4
	23. Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)? Yes No Don't Know	0	1	2	3	4
XII	24. In the past TWO (2) WEEKS, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide? Yes No Don't Know	0	1	2	3	4
	25. Has he/she EVER tried to kill himself/herself? Yes No Don't Know	0	1	2	3	4