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

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

	During the past TWO (2) WEEKS, how much (or how often) have you…	None	Few days	Some days	Most days	Severe daily
I	1. Been bothered by stomach aches, 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
II	3. Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4
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?	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 VI	7. Felt more irritated or easily annoyed than usual?	0	1	2	3	4
	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
VII I	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
XI	XI. 20. Had an alcoholic beverage (beer, wine, liquor, etc.)? Yes No	0	1	2	3	4
	21. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco? Yes No	0	1	2	3	4
	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)? Yes No	0	1	2	3	4
	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)? Yes No	0	1	2	3	4
XII	24. In the last 2 weeks, have you thought about killing yourself or committing suicide? Yes No	0	1	2	3	4
	25. Have you EVER tried to kill yourself? Yes No	0	1	2	3	4