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

Child's Name _____ Age _____ Date _____

Relationship with the child _____ Sex: □ Male □ Female

Instructions (to the parent or guardian of child): The questions below ask about things that might have bothered your child. For each question, circle the numbers that best describes how much (or how often) your child has been bothered by each problem during the past **TWO (2) WEEKS**.

		During the past **TWO (2) WEEKS**, how much or how often has your child...	**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)
I	1	Complained of stomachaches, 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- that is, 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 use to?	0	1	2	3	4	
	6	Seemed sad or depressed for several hours?	0	1	2	3	4	
V	7	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI	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	
VIII	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 thing 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 the 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 that 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 or having germs or 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	
		In the past **TWO (2) WEEKS** has your child...						
XI	20	Had an alcoholic beverage (beer, wine, liquor, etc.)	Yes		No	Don't Know		
	21	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	Yes		No	Don't Know		
	22	Used drugs like marijuana, cocaine, crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	Yes		No	Don't Know		
	23	Used any medication 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		
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		
	25	Has he/she EVER tried to kill himself/herself?	Yes		No	Don't Know		