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

Name: ______________________ Age: ____ Sex: ☐ Male ☐ Female 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.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you...	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.	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	
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	
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 the past **TWO (2) WEEKS,** have you...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes			☐ No		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes			☐ 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)?	☐ Yes			☐ 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)?	☐ Yes			☐ No		
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes			☐ No		
	25.	Have you EVER tried to kill yourself?	☐ Yes			☐ No		

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CAGE

Alcohol or Drug Use:

How often do you have a dink containing alcohol?

Never	☐
Monthly or less	☐
Two to four times per week	☐
Four or more times per week	☐

How often do you use a non-prescribed drug?

Never	☐
Monthly or less	☐
Two to four times per week	☐
Four or more times per week	☐

How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2	☐
3 or 4	☐
5 or 6	☐
7 to 9	☐
10 or more	☐

How many non-prescribed drugs do you have on a typical day when you are taking non-prescribed drugs?

1 or 2	☐
3 or 4	☐
5 or 6	☐
7 to 9	☐
10 or more	☐

Drink or Drug of Choice? ____

Have you ever felt the need to cut down on your drinking or drug use? ________________
Have you ever felt annoyed by criticism of your drinking or drug use? ________________
Have you ever had guilty feelings about your dinking or drug use? ________________
Have you ever taken a morning eye opener? ________________________
Have you ever missed work/school due to your drinking or drug use? ________________

Is a follow up appointment needed? ____________________________________

______________________________________ ______________
Clinician Signature Date