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

Child's Name:	Age:	Sex: 🗆 Male 🖵 Female	Date:
Relationship with the child:			
<b>Instructions</b> (to the parent or guardian of child): The question: question, circle the number that best describes how much (or past TWO (2) WEEKS.		-	•

			None Not at	Slight Rare, less than a day		Moderate More than half the	Severe Nearly every	Highest Domain Score
	Duri	ng the past <b>TWO (2) WEEKS,</b> how much (or how often) has your child		or two	,	days	day	(clinician)
l. :	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 used 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 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	
	1 / 1	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	
		Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
		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 th	e past <b>TWO (2) WEEKS,</b> has your child						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?		Yes $\square$	No	□ Don't	Know	
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?		Yes 🗆	l No	☐ Don't	Know	
;	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 🗆	l No	□ Don't	Know	
;	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 🗆	l No	□ Don't	Know	
XII.	24.	In the past <b>TWO (2) WEEKS,</b> has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?		Yes 🗆	l No	□ Don't	Know	
	25.	Has he/she EVER tried to kill himself/herself?		Yes 🗆	l No	☐ Don't	Know	