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: _____

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 number 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 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	
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	
	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 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 or 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 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		
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		

Copyright © 2013 American Psychiatric Association. All Rights Reserved.
This material can be reproduced without permission by researchers and by clinicians for use with their patients.