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. &	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	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		

LEVEL 2—Substance Use—Child Age 11–17*

*Adapted from the NIDA-Modified ASSIST

Name: _____ Age: ____ Sex: ☐ Male ☑ Female Date: _____

Instructions to the child: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you have been bothered by "having an alcoholic beverage"; "smoking a cigarette, a cigar, or pipe or used snuff or chewing tobacco"; "using drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)"; and/or "using any medicine ON YOUR OWN, that is, without a doctor's prescription, to get high or change the way you feel." The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms **during the past two (2) weeks. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
		Not at All	Less Than a Day or Two	Several Days	More Than Half the Days	Nearly Every Day	Item Score
During the past TWO (2) weeks, about how often did you ...							
a.	Have an alcoholic beverage (beer, wine, liquor, etc.)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
b.	Have 4 or more drinks in a single day?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
c.	Smoke a cigarette, a cigar, or pipe or use snuff or chewing tobacco?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
During the past TWO (2) weeks, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription or in greater amounts or longer than prescribed?							
d.	Painkillers (like Vicodin)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
e.	Stimulants (like Ritalin, Adderall)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
f.	Sedatives or tranquilizers (like sleeping pills or Valium)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
Or drugs like:							
g.	Steroids	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
h.	Other medicines	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
i.	Marijuana	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
j.	Cocaine or crack	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
k.	Club drugs (like ecstasy)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
l.	Hallucinogens (like LSD)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
m.	Heroin	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
n.	Inhalants or solvents (like glue)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
o.	Methamphetamine (like speed)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	