

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

Name: \_\_\_\_\_

Age: \_\_\_\_\_

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**.

		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)
		During the past <b>TWO (2) WEEKS</b> , how much (or how often) have you...					
I.	1.	0	1	2	3	4	
	2.	0	1	2	3	4	
II.	3.	0	1	2	3	4	
III.	4.	0	1	2	3	4	
IV.	5.	0	1	2	3	4	
	6.	0	1	2	3	4	
V. & VI.	7.	0	1	2	3	4	
	8.	0	1	2	3	4	
VII.	9.	0	1	2	3	4	
	10.	0	1	2	3	4	
VIII.	11.	0	1	2	3	4	
	12.	0	1	2	3	4	
	13.	0	1	2	3	4	
IX.	14.	0	1	2	3	4	
	15.	0	1	2	3	4	
X.	16.	0	1	2	3	4	
	17.	0	1	2	3	4	
	18.	0	1	2	3	4	
	19.	0	1	2	3	4	
		In the past <b>TWO (2) WEEKS</b> , have you...					
XI.	20.	<input type="checkbox"/> Yes		<input type="checkbox"/> No			
	21.	<input type="checkbox"/> Yes		<input type="checkbox"/> No			
	22.	<input type="checkbox"/> Yes		<input type="checkbox"/> No			
	23.	<input type="checkbox"/> Yes		<input type="checkbox"/> No			
XII.	24.	<input type="checkbox"/> Yes		<input type="checkbox"/> No			
	25.	<input type="checkbox"/> Yes		<input type="checkbox"/> No			