

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child

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.

		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 TWO (2) WEEKS, how much (or how often) has your child...					
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. &	7.	0	1	2	3	4	
VI.	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 TWO (2) WEEKS, has your child ...					
XI.	20.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	21.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	22.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	23.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
XII.	24.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	25.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			