

## DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

**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 <b>TWO (2) WEEKS</b> , how much (or how often) have you been bothered by the following problems?  | None<br>Not at<br>all | Slight<br>Rare, less<br>than a day<br>or two | Mild<br>Several<br>days | Moderate<br>More than<br>half the<br>days | Severe<br>Nearly<br>every<br>day | Highest<br>Domain<br>Score<br>(clinician) |
|-------|---|-----------------------|--|-------------------------|---|----------------------------------|---|
| I.    | 1. Little interest or pleasure in doing things?   | 0                     | 1  | 2                       | 3   | 4                                |   |
|       | 2. Feeling down, depressed, or hopeless?  | 0                     | 1  | 2                       | 3   | 4                                |   |
| II.   | 3. Feeling more irritated, grouchy, or angry than usual?  | 0                     | 1  | 2                       | 3   | 4                                |   |
| III.  | 4. Sleeping less than usual, but still have a lot of energy?  | 0                     | 1  | 2                       | 3   | 4                                |   |
|       | 5. Starting lots more projects than usual or doing more risky things than usual?  | 0                     | 1  | 2                       | 3   | 4                                |   |
| IV.   | 6. Feeling nervous, anxious, frightened, worried, or on edge?   | 0                     | 1  | 2                       | 3   | 4                                |   |
|       | 7. Feeling panic or being frightened?   | 0                     | 1  | 2                       | 3   | 4                                |   |
|       | 8. Avoiding situations that make you anxious?   | 0                     | 1  | 2                       | 3   | 4                                |   |
| V.    | 9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?   | 0                     | 1  | 2                       | 3   | 4                                |   |
|       | 10. Feeling that your illnesses are not being taken seriously enough?   | 0                     | 1  | 2                       | 3   | 4                                |   |
| VI.   | 11. Thoughts of actually hurting yourself?  | 0                     | 1  | 2                       | 3   | 4                                |   |
| VII.  | 12. Hearing things other people couldn't hear, such as voices even when no one was around?  | 0                     | 1  | 2                       | 3   | 4                                |   |
|       | 13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?   | 0                     | 1  | 2                       | 3   | 4                                |   |
| VIII. | 14. Problems with sleep that affected your sleep quality over all?  | 0                     | 1  | 2                       | 3   | 4                                |   |
| IX.   | 15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?   | 0                     | 1  | 2                       | 3   | 4                                |   |
| X.    | 16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?  | 0                     | 1  | 2                       | 3   | 4                                |   |
|       | 17. Feeling driven to perform certain behaviors or mental acts over and over again?   | 0                     | 1  | 2                       | 3   | 4                                |   |
| XI.   | 18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?   | 0                     | 1  | 2                       | 3   | 4                                |   |
| XII.  | 19. Not knowing who you really are or what you want out of life?  | 0                     | 1  | 2                       | 3   | 4                                |   |
|       | 20. Not feeling close to other people or enjoying your relationships with them?   | 0                     | 1  | 2                       | 3   | 4                                |   |
| XIII. | 21. Drinking at least 4 drinks of any kind of alcohol in a single day?  | 0                     | 1  | 2                       | 3   | 4                                |   |
|       | 22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?  | 0                     | 1  | 2                       | 3   | 4                                |   |
|       | 23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]? | 0                     | 1  | 2                       | 3   | 4                                |   |

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

Date: \_\_\_\_\_

Please indicate how much you have been bothered in the past two weeks by:

Circle One

|                                       | Not at All | Some | A Lot | Extremely |
|---------------------------------------|------------|------|-------|-----------|
| Feeling Fearful                       | Not at All | Some | A Lot | Extremely |
| Difficulty Making Decisions           | Not at All | Some | A Lot | Extremely |
| Feeling Insecure                      | Not at All | Some | A Lot | Extremely |
| Nightmares                            | Not at All | Some | A Lot | Extremely |
| Trembling                             | Not at All | Some | A Lot | Extremely |
| Chest Pain                            | Not at All | Some | A Lot | Extremely |
| Feeling Dizzy                         | Not at All | Some | A Lot | Extremely |
| Fear of Losing Control                | Not at All | Some | A Lot | Extremely |
| Confronting Life<br>Threatening Event | Not at All | Some | A Lot | Extremely |
| Unpleasant Flashbacks                 | Not at All | Some | A Lot | Extremely |
| Difficulty Falling Asleep             | Not at All | Some | A Lot | Extremely |
| Feeling Hopeless<br>About the Future  | Not at All | Some | A Lot | Extremely |
| Feeling Guilty                        | Not at All | Some | A Lot | Extremely |
| Difficulty Staying Asleep             | Not at All | Some | A Lot | Extremely |
| Difficulty Staying Awake              | Not at All | Some | A Lot | Extremely |
| Thoughts of Suicide                   | Not at All | Some | A Lot | Extremely |
| Not Having Feeling                    | Not at All | Some | A Lot | Extremely |
| Poor Appetite                         | Not at All | Some | A Lot | Extremely |
| Low Energy                            | Not at All | Some | A Lot | Extremely |

|   |                   |             |              |                  |
|---|-------------------|-------------|--------------|------------------|
| <b>Low Self Esteem</b>                            | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Sexual Problems</b>                            | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Feeling Angry</b>                              | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Getting Into Arguments</b>                     | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Problems with Other People</b>                 | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Speeded Up Thoughts</b>                        | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>People Telling You To Slow Down</b>            | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Change In Your Personality</b>                 | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Being Incoherent in Your Speech</b>            | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Being Disorganized In Your Behavior</b>        | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Radical Mood Swings</b>                        | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Persistent Elevation of Mood</b>               | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Flights of Unconnected Ideas</b>               | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Risky but Pleasurable Activities</b>           | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Organizing Tasks</b>                           | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Being Easily Distracted</b>                    | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Sustaining Attention</b>                       | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Poor Performance on Job<br/>(or in School)</b> | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Suspicious of Others</b>                       | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Bulimia</b>                                    | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |
| <b>Anorexia Nervosa</b>                           | <b>Not at All</b> | <b>Some</b> | <b>A Lot</b> | <b>Extremely</b> |

## Mental Health

Please identify any prior counseling you have had and the reason starting with the most recent:

| Start/End Dates: | Location | Reason | Comments |
|------------------|----------|--------|----------|
|                  |          |        |          |
|                  |          |        |          |
|                  |          |        |          |
|                  |          |        |          |

Have you ever considered suicide recently or in the past? ☐ No ☐ Yes, if so please give a brief description with dates:

Have you ever attempted suicide recently or in the past? ☐ No ☐ Yes, if so please give a brief description with dates:

Have you had any homicidal thoughts or considered homicide? ☐ No ☐ Yes, if so please give a brief description with dates:

**Thoughts:** Please check any of the following that apply to you:

☐ I sometimes hear voices even though no one nearby is talking to me.

☐ I sometimes feel that forces outside of me control me.

☐ I sometimes feel that other people control my thoughts.

☐ I sometimes have the same thought over and over and cannot control it.

☐ I sometimes feel that someone is out to hurt me or do something against me.

☐ I am sometimes unable to control my behavior. Please Explain: \_\_\_\_\_

## Treatment/Goal Planning

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your goals for therapy. "When I am done with therapy, I will know because I will ..."

To the best of my knowledge, this information is true and accurate.

Signature: \_\_\_\_\_

Therapist Initials/Date: \_\_\_\_\_