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

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

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

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 been bothered by the following problems?	**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. 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	

Initials _____

Severity Measure for Depression—Adult*

*Adapted from the Patient Health Questionnaire–9 (PHQ-9)

Name:_____ **Age:** _____ **Sex: Male** ☐ **Female** ☐ **Date:**_____

Instructions: Over the **last 7 days**, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)

						Clinician Use
						Item score
		Not at all	Several days	More than half the days	Nearly every day	
1.	Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐	
2.	Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐	
3.	Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐	
4.	Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐	
5.	Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐	
6.	Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐	
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐	
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐	
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐	
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Adapted from Patient Health Questionnaire—9 (PHQ-9) for research and evaluation purposes.

Initials _____

Severity Measure for Generalized Anxiety Disorder—Adult

Name:_____ **Age:** _____ **Sex: Male** ☐ **Female** ☐ **Date:**_____

Instructions: The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work. **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
	During **the PAST 7 DAYS**, I have...	**Never**	**Occasionally**	**Half of the time**	**Most of the time**	**All of the time**	**Item score**
1.	felt moments of sudden terror, fear, or fright	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
2.	felt anxious, worried, or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
3.	had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
6.	avoided, or did not approach or enter, situations about which I worry	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
7.	left situations early or participated only minimally due to worries	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
8.	spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
9.	sought reassurance from others due to worries	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
10.	needed help to cope with anxiety (e.g., alcohol or medication, superstitious objects, or other people)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
						Total/Partial Raw Score:	
						Prorated Total Raw Score: (if 1-2 items left unanswered)	
						Average Total Score:	

LEVEL 2—Substance Use—Adult*

*Adapted from the NIDA-Modified ASSIST

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

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

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, in greater amounts or longer than prescribed?							**Clinician Use**
		Not at all	**One or two days**	**Several days**	**More than half the days**	**Nearly every day**	**Item Score**
a.	Painkillers (like Vicodin)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
b.	Stimulants (like Ritalin, Adderall)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
c.	Sedatives or tranquilizers (like sleeping pills or Valium)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
Or drugs like:							
d.	Marijuana	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
e.	Cocaine or crack	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
f.	Club drugs (like ecstasy)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
g.	Hallucinogens (like LSD)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
h.	Heroin	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
i.	Inhalants or solvents (like glue)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
j.	Methamphetamine (like speed)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
						Total Score:	

Initials _____