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.**

In the past **TWO (2) WEEKS,** have you…		
Had an alcoholic beverage (beer, wine, liquor, etc.)?	◯ Yes	◯ No
Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	◯ Yes	◯ No
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
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

Instructions: If you answered "yes" to any of the questions above, please complete the second page of this form.

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

*Adapted from the NIDA-Modified ASSIST

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…						
Have an alcoholic beverage (beer, wine, liquor, etc.)?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
Have 4 or more drinks in a single day?	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
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?						
Painkillers (like Vicodin)	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
Stimulants (like Ritalin, Adderall)	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
Sedatives or tranquilizers (like sleeping pills or Valium)	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
Or drugs like:						
Steroids	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
Other medicines	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
Marijuana	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
Cocaine or crack	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
Club drugs (like ecstasy)	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
Hallucinogens (like LSD)	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
Heroin	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
Inhalants or solvents (like glue)	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	
Methamphetamine (like speed)	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	