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, select 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	

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UNIFIED COMMUNITY SERVICES
INTAKE HISTORY

NAME ____ DATE ________________

Please answer the following questions. Your answers will help us develop a comprehensive understanding of your concerns. If you need more space, please use the back of the page.

I. Briefly describe the problem that brought you here today:

____

____

____

II. Are you currently feeling suicidal? __________

If yes, how frequently in the last 48 hours have you thought about dying? ______________________ If yes, do you have a plan? ____

III. Please describe any past mental health treatment you've had. Include where you received treatment, date, and type of treatment:

____

____

____

Have you ever been hospitalized for emotional problems? _____ If yes, please describe:

____

____

Please list medications you have previously taken for mental health problems. Indicate any side effects, whether or not the medication was helpful, and how long you took the medication:

____

____

____

IV. Please describe any significant life events that may be influencing your current problem (for example, past abuse, family problems, loss of family member, divorce, etc.):

____

____

Please list the people living in your home, including each person's age and relationship to you:

____

____

NAME ____ DATE ________________

V. Please describe your current or past legal problems:

____

____

____

VI. Please describe any problems you had or are having in school:

____

____

If currently attending school, what grade are you in? ___________________

If you are not in school, what was the highest grade you completed? __________________

VII. Please tell us about your blood relatives who have had mental health and/or substance abuse problems. Include suicides and significant legal problems. Describe the nature of the problem:

____

____

____

____

VIII. Name of your primary medical doctor: ____

Name(s) of other doctors you see: ____

Date of last complete physical: ____

Current health concerns: ____

Are you currently pregnant? ____

Allergies: ____

List all prescription, over-the-counter, and herbal medications you are currently taking. Include dosage and side effects:

____

____

Has a doctor recommended or prescribed medicine that you are not taking? ____ If yes, please explain:

____

Current height and weight: ____

Please select any physical health problems that you or your blood relatives have encountered:

Diabetes Heart disease High blood pressure Cancer Stroke

Seizures Thyroid Disorder Migraines TB Asthma Ulcers

NAME ____ DATE ________________

How much and what type of caffeinated beverages do you drink each day?

____

Describe the frequency, amount and how long you used the following substances:

Marijuana: ____

Street drugs (e.g. Cocaine, speed, acid, angel dust):

____

Alcohol: ____

Tobacco: ____

Other: ____

Are you currently having problems related to these substances?:

____

Have you ever been treated for problems with alcohol or drugs?

____

Have you ever been hospitalized for problems with alcohol or drugs?

____

Have you ever been placed in detox? ____

IX. Below is a list of concerns that people report. Please select any that are problematic for you:

Sleeping	Eating	Alcohol	Concentration
Memory decline	Shame	Guilt	Decision making
Anxiety	Depression	Fear	Worries
Feeling down	Over spending	Irritability	Anger outbursts
Hitting others	Suicidal thoughts	Verbal abuse	Poor frustration tolerance
Hallucinations	Being hit/hurt	Mood swings	Sexual difficulties
Nightmares	Panic attacks	Hopelessness	Sadness
Mind racing	Unwanted thoughts	Breaking things	Hurting yourself
Communication	Flashbacks	Hoarding/collecting	Being picked on

X. Please share any other information that will help us understand your problems:

____

____

Signature of Person Who Completed This Form ___________________________________ 7/2023

NAME: ______________________________________ DATE:________________

Please add any additional information on this page:

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UNIFIED COMMUNITY SERVICES

Today's Date ______________

CLIENT INFORMATION

Legal Name: ________________________________
(First, Middle, Last)

Maiden Name: ______________ Previous Married Names, Alias, etc. ______________

Address: ________________________________
Street City State Zip Code

County of Residence: ________ DOB: ________ Legal Gender: ________ Gender at Birth: ________

Gender Identity: ______________ Social Security Number: ______________

Cell Phone: ______________ I request text appointment reminders Yes * No

Home Phone: ______________ Email Address: ______________

Race: (Select all that apply): White Black/African American Asian Pacific Islander/Native Hawaiian Other Race American Indian/Alaskan Native

Ethnicity (Select one): Hispanic or Latino Not Hispanic or Latino

Veteran: Yes No

Marital Status (Select one): Married Single Widowed Divorced Separated Legally Separated

Disability (Select one): Not disabled Physically Disabled Mentally Disabled

FAMILY INFORMATION/EMERGENCY CONTACT

Spouse, Parent(s), Legal Guardian or Next of Kin

____
Name Relationship Phone Number

____
Street City State Zip Code

REFERRAL INFORMATION

Who referred you to Unified Community Services? ______________
(Spouse, Friend, Physician, Court, Teacher, Employer, Etc)

MEDICAL INFORMATION

Family Physician: ________________________________
Physician Name Clinic Name City State

Pharmacy: ________________________________
Pharmacy Name City State Phone Number

Power of Attorney for Health Care: ______________
Name

____
Address Phone Number

Activated? (Select one): No Yes Date (if yes): ______________

INSURANCE INFORMATION

Company Name: ________________________________

Policy Holder: ______________ DOB: ________

Policyholder's Employer: ______________

Subscriber ID No: ______________ Group Number: ________

Medical Assistance # ______________ Medicare # ______________