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, 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…	**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.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	❑ Yes			❑ No		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	❑ Yes			❑ No		
	22.	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		
	23.	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		
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	❑ Yes			❑ No		
	25.	Have you EVER tried to kill yourself?	❑ Yes			❑ No		

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DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

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, select the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**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.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	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	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

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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 # ____________________