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			

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 <u>past</u> 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 <u>previously</u> 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:

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 # _____