STRICTLY CONFIDENTIAL CAPSS No ☐☐☐

Conversion Disorder in children under sixteen years of age

CHILD AND ADOLESCENT PSYCHIATRY SURVEILLANCE SYSTEM

General Information

Hospital or centre:……

Consultant Responsible for diagnosis of reported Case: ……

Person completing Questionnaire: ……

Contact Telephone Number: ……Email……

Patient details:

1.1. Patient NHS Number: (if available)……

1.2. Date of Birth (dd/mm/yy): ☐☐/☐☐/☐☐

1.3. Sex (please circle): Male / Female

1.4. Post-code (first part only): ☐☐☐☐

Date child presented: ☐☐/☐☐/☐☐

Date form completed: ☐☐/☐☐/☐☐

Patient ethnicity (please tick):

WHITE:	☐ British	BLACK:	☐ African
	☐ Irish		☐ Caribbean
	☐ Other (describe below)		☐ Other (describe below)
MIXED:	☐ White and Black Caribbean	ASIAN:	☐ Bangladeshi
	☐ White and Black African		☐ Indian
	☐ White and Asian		☐ Pakistani
	☐ Other (describe below)		☐ Other (describe below)
CHINESE:	☐ Chinese	OTHER:	☐ Other (describe below)

2.1. If "Other" chosen, please describe: ………

For further information or queries, please contact: Dr Cornelius Ani

Please return completed form in the pre-paid envelope to: **Dr Cornelius Ani Academic Unit of Child and Adolescent Psychiatry, Imperial College London, St. Mary's Campus, Norfolk Place, London W2 1PG, Tel: 020 7886 1145 Fax: 020 7886 6299, Mobile: 07752161522, e-mail: c.ani@imperial.ac.uk**

Presenting clinical details

1. **Did this young person present with one or more motor or sensory symptoms not medically explained by history, physical examination or investigations (excluding primary fatigue/malaise presentations)?**

   Yes ☐ No ☐

2. **Is there evidence that the symptom(s) have been intentionally produced by the child?**

   Yes ☐ No ☐

3. **Has any of the symptoms lasted 7 days or longer?**

   Yes ☐ No ☐

4. **Is this the first episode of Conversion Disorder (i.e. medically unexplained motor/sensory symptoms)?**

   Yes ☐ No, recurrence ☐ Not Known ☐

   If a recurrence, how many previous episodes?:……..

5. **Is there <u>a history of any</u> of the following psychiatric conditions diagnosed by a psychiatrist in this child prior to onset of this episode of conversion disorder?**

Depressive disorder	Yes ☐	No ☐	Not Known ☐
Any anxiety disorder	Yes ☐	No ☐	Not Known ☐
School phobia	Yes ☐	No ☐	Not Known ☐
Conduct or oppositional defiant disorder	Yes ☐	No ☐	Not Known ☐
Bipolar Affective Disorder	Yes ☐	No ☐	Not Known ☐
Any Psychotic illness	Yes ☐	No ☐	Not Known ☐
Post-traumatic stress disorder	Yes ☐	No ☐	Not Known ☐
Attention deficit hyperactivity (hyperkinetic) disorder	Yes ☐	No ☐	Not Known ☐
Autistic Spectrum Disorder	Yes ☐	No ☐	Not Known ☐

   Any other mental disorder (please state):
   ……

6. **Is there another <u>current psychiatric</u> condition diagnosed by a psychiatrist in this child?**

Depressive disorder	Yes ☐	No ☐	Not Known ☐
Any anxiety disorder	Yes ☐	No ☐	Not Known ☐
School phobia	Yes ☐	No ☐	Not Known ☐
Conduct or oppositional defiant disorder	Yes ☐	No ☐	Not Known ☐
Bipolar Affective Disorder	Yes ☐	No ☐	Not Known ☐
Any Psychotic illness	Yes ☐	No ☐	Not Known ☐
Post-traumatic stress disorder	Yes ☐	No ☐	Not Known ☐
Attention deficit hyperactivity (hyperkinetic) disorder	Yes ☐	No ☐	Not Known ☐
Autistic Spectrum Disorder	Yes ☐	No ☐	Not Known ☐

   Any other mental disorder (please state):
   ……

7. **Is there a history of a medical condition requiring paediatric inpatient and or outpatient consultation in this child in the one year to onset of Conversion disorder?**
   Please state what medical condition and indicate if still active at time of diagnosis of Conversion Disorder?

<u>Medical condition</u>	<u>Indicate if still active</u>		
_____	Yes ☐	No ☐	Not Known ☐
_____	Yes ☐	No ☐	Not Known ☐
_____	Yes ☐	No ☐	Not Known ☐
_____	Yes ☐	No ☐	Not Known ☐

Family History Details

8. Is there a history of psychiatric disorder in a biological or step-parent or biological or step-sibling of this child currently or within a year to the onset of this episode of conversion disorder?

Depressive disorder	Yes ☐ Relationship to child----------	No ☐	Not Known ☐
Any anxiety disorder	Yes ☐ Relationship to child----------	No ☐	Not Known ☐
Bipolar Affective Disorder	Yes ☐ Relationship to child----------	No ☐	Not Known ☐
Any Psychotic illness	Yes ☐ Relationship to child----------	No ☐	Not Known ☐
Alcohol and or drug dependence	Yes ☐ Relationship to child----------	No ☐	Not Known ☐
Posttraumatic stress disorder	Yes ☐ Relationship to child----------	No ☐	Not Known ☐
Conversion disorder	Yes ☐ Relationship to child----------	No ☐	Not Known ☐

Any other mental disorder (please state condition and which relative(s) are affected:
……

9. Is there a history of medical disorder requiring outpatient and or inpatient treatment in a biological or step parent or biological or step sibling currently or within a year to the onset of Conversion disorder in this child?

Asthma	Yes ☐ Relationship to child----------	No ☐	Not Known ☐
Diabetes Mellitus	Yes ☐ Relationship to child----------	No ☐	Not Known ☐
Arthritis	Yes ☐ Relationship to child----------	No ☐	Not Known ☐
Epilepsy	Yes ☐ Relationship to child----------	No ☐	Not Known ☐
Neurological except epilepsy	Yes ☐ Relationship to child----------	No ☐	Not Known ☐
Cancer of any type	Yes ☐ Relationship to child----------	No ☐	Not Known ☐
Heart Disease of any kind.	Yes ☐ Relationship to child----------	No ☐	Not Known ☐

Any other physical disorder (please state condition and which relative(s) are affected:
……

Clinical details

10. How long was the period between the first appearance of a typical symptom or sign of conversion disorder to confirmation of the diagnosis?

<1 week ☐ ≥1week to <1 month ☐ ≥1 month to <6 months ☐ ≥12 months ☐

11. Has the child experienced any of the following life stresses within a year to the onset of this episode of conversion disorder?

Parental separation	Yes ☐	No ☐	Not Known ☐
Death of a relative or friend	Yes ☐	No ☐	Not Known ☐
Bullying requiring school action	Yes ☐	No ☐	Not Known ☐
Abuse requiring Social Services referral	Yes ☐	No ☐	Not Known ☐
Hospital admission of a parent or sibling	Yes ☐	No ☐	Not Known ☐
School examination e.g. 11 plus, GCSE	Yes ☐	No ☐	Not Known ☐
Break-up with a best friend	Yes ☐	No ☐	Not Known ☐

Any other stress you consider significant (please state):
……

Main symptoms at presentation and after diagnosis

12. Please indicate which of the following feature(s) had been present for up to 7 days <u>from when the child first presented until the time the diagnosis</u> of this episode of conversion disorder was confirmed? (tick as many features as apply and include features that may have resolved after 7 days)

Pseudo seizure	Yes ☐		No ☐	Not Known ☐
Motor weakness	Yes ☐	Please describe site----------	No ☐	Not Known ☐
Paralysis	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Abnormal movements	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Hearing disturbance	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Visual disturbance.	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Abnormal or loss of speech	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Diminished consciousness.	Yes ☐		No ☐	Not Known ☐

OTHER ASSOCIATED FEATURES

Pain	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Fatigue	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Anaesthesia / Paraesthesia	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Dysphagia (including lump in throat).	Yes ☐	Please describe ----------	No ☐	Not Known ☐
Vomiting	Yes ☐		No ☐	Not Known ☐
La belle indifference (e.g. marked lack of concern in the child about severity of symptoms / signs).	Yes ☐	Possibly ☐	No ☐	Not Known ☐

Any other feature not mentioned.
……

13. Please indicate which of the following features <u>subsequently appeared after the diagnosis</u> of this episode of conversion disorder had been confirmed? (include any features that appeared for the first time after the diagnosis had been confirmed and until the time of completion of this questionnaire)

Pseudo seizure	Yes ☐		No ☐	Not Known ☐
Motor weakness	Yes ☐	Please describe site----------	No ☐	Not Known ☐
Paralysis	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Abnormal movements	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Hearing disturbance	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Visual disturbance.	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Abnormal or loss of speech	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Diminished consciousness.	Yes ☐		No ☐	Not Known ☐

OTHER ASSOCIATED FEATURES

Pain	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Fatigue	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Anaesthesia / Paraesthesia	Yes ☐	Please describe site ----------	No ☐	Not Known ☐
Dysphagia (including lump in throat).	Yes ☐	Please describe ----------	No ☐	Not Known ☐
Vomiting	Yes ☐		No ☐	Not Known ☐
La belle indifference (e.g. marked lack of concern in the child about severity of symptoms / signs).	Yes ☐	Possibly ☐	No ☐	Not Known ☐

Any other feature not mentioned.
……

Investigations

14. Please indicate if any of the following investigations were performed
(if yes, please indicate site assessed where possible)

				If yes, site assessed
EEG	Yes ☐	No ☐	Not Known ☐	
Nerve conduction	Yes ☐	No ☐	Not Known ☐	……
MRI	Yes ☐	No ☐	Not Known ☐	……
CT scan	Yes ☐	No ☐	Not Known ☐	……
X-Rays	Yes ☐	No ☐	Not Known ☐	……
EMG	Yes ☐	No ☐	Not Known ☐	……
Video telemetry	Yes ☐	No ☐	Not Known ☐	

Any other investigations not yet mentioned (excluding routine blood and Urine tests):
……

Management

15. Did the child require admission to hospital for this episode of conversion disorder? Yes ☐ No ☐ Not Known ☐

If the child has already been discharged, what was the total duration of hospital admission? …… (days)

If the child has not been discharged, what is the total duration of admission to date? ……(days)

16. Were psychotropic medications prescribed for another co-existing psychiatric disorder? Yes ☐ No ☐ Not Known ☐

If "yes", please specify the medication(s) ……and the disorder(s)……

17. Please indicate which of the following health professionals, services, or agencies have been providing care for this child during this episode of conversion disorder?

General paediatrician	Yes ☐	No ☐	Not Known ☐
Paediatric Neurologist	Yes ☐	No ☐	Not Known ☐
Child Psychiatrist	Yes ☐	No ☐	Not Known ☐
Physiotherapist	Yes ☐	No ☐	Not Known ☐
Occupational therapists	Yes ☐	No ☐	Not Known ☐
Clinical psychologist	Yes ☐	No ☐	Not Known ☐
Educational Psychologist	Yes ☐	No ☐	Not Known ☐
Social worker	Yes ☐	No ☐	Not Known ☐
Education (e.g. Teachers)	Yes ☐	No ☐	Not Known ☐

Any other professional or agency not yet mentioned:
……

Thank you

Thank you for completing this questionnaire. The investigations and treatment may be complete for this child, or there may be further tests or more information expected. If you believe this to be the case would you please indicate in the relevant boxes below.

Information likely to be complete ☐

Further information likely to become available ☐

If further information is likely, when would be a suitable time for us to contact you again

3 months ☐

6 months ☐

12 months ☐

Please give a means of contact (tel, fax, email, or address) and we suggest you retain a record of the child's identity so you can trace the notes when we contact you again