FOLLOW-UP QUESTIONNAIRE

STRICTLY CONFIDENTIAL

CAPSS No ☐☐☐

Conversion Disorder in children under sixteen years of age

BRITISH PAEDIATRIC SURVEILLANCE UNIT

General Information

Hospital or centre:..

Consultant Responsible for 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 ☐ Irish ☐ Other (describe below)	BLACK:	☐ African ☐ Caribbean ☐ Other (describe below)
MIXED:	☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Other (describe below)	ASIAN:	☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ 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

Follow up

1. **If the child required admission for this episode of conversion disorder, how long was he / she an inpatient?** …………….(weeks)

2. **Length of out-patient treatment (if applicable) ………… (weeks)**

3. **Please indicate outcome and the extent to which the child's original presenting symptoms have improved by ticking the relevant boxes below.**

Symptom	Improved	Not improved	Worse	Not known
Pseudo seizure	☐	☐	☐	☐
Motor weakness	☐	☐	☐	☐
Paralysis	☐	☐	☐	☐
Abnormal movements	☐	☐	☐	☐
Hearing disturbance	☐	☐	☐	☐
Visual disturbance.	☐	☐	☐	☐
Abnormal or loss of speech	☐	☐	☐	☐
Diminished consciousness.	☐	☐	☐	☐
Pain	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Anaesthesia / Paraesthesia	☐	☐	☐	☐
Dysphagia (including lump in throat).	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐
La belle indifference (e.g. marked lack of concern in the child about severity of symptoms / signs).	☐	☐	☐	☐

5. **Since completing the initial questionnaire, was the child subsequently diagnosed with any of the following psychiatric conditions by a psychiatrist?**

Condition	Yes	No	Not Known
Depressive disorder	Yes ☐	No ☐	Not Known ☐
Any anxiety disorder	Yes ☐	No ☐	Not Known ☐
School phobia	Yes ☐	No ☐	Not Known ☐
Post traumatic stress disorder	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 ☐
Attention deficit hyperactivity disorder	Yes ☐	No ☐	Not Known ☐
Autistic Spectrum Disorder	Yes ☐	No ☐	Not Known ☐

Any other mental disorder (please state):
……………………………………………………………………………………………………

6. **Since completing the initial questionnaire, has more information become available to indicate that the child had experienced any of the following life stresses within a year to the onset 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):
………

7. **Were psychotropic medications prescribed for the child?** Yes ☐ No ☐ Not Known ☐

If "yes", please specify the medication(s) ………..and the condition(s) they were prescribed for………..

8. **Was a non-physical cause for the symptom(s) explained to the family?** Yes ☐ No ☐ Not Known ☐

9. **If the answer to question 8 above is "yes", to what extent was a non-physical contribution/explanation for the symptoms accepted by the parents / care givers?**

Completely rejected ☐ Accepted a little ☐ Well Accepted ☐ Not known ☐

10. **Please indicate if any of the following psychological therapies were offered and whether they were accepted by the parents / care givers**

Psychological Therapy	Offered	Accepted	Not known
Psychoeducation (links physical/psychological)	☐	☐	☐
Anxiety management e.g. relaxation	☐	☐	☐
Behaviour Therapy	☐	☐	☐
Family Therapy	☐	☐	☐
Cognitive Behaviour Therapy	☐	☐	☐
Supportive counselling	☐	☐	☐
Psychodynamic therapy	☐	☐	☐

Any other psychological therapy not mentioned (please state):
………

11. **Please indicate which of the following health professionals, services, or agencies provided care for this child during this episode of conversion disorder?**

General paediatrician	Yes ☐	No ☐	Not Known ☐
Child Psychiatrist	Yes ☐	No ☐	Not Known ☐
Occupational therapists	Yes ☐	No ☐	Not Known ☐
Clinical psychologist	Yes ☐	No ☐	Not Known ☐
Educational Psychologist	Yes ☐	No ☐	Not Known ☐
Paediatric Neurologist	Yes ☐	No ☐	Not Known ☐
Physiotherapist	Yes ☐	No ☐	Not Known ☐
Social worker	Yes ☐	No ☐	Not Known ☐
Education	Yes ☐	No ☐	Not Known ☐

Any other professional or agency not yet mentioned:
……………………………………………………………………………………………

Thank you for your help with this research project.