CONVERSION DISORDER QUESTIONNAIRE

Australian Paediatric Surveillance Unit

Please ring Donna Rose on 02 9845 2200 if you have any problems with this questionnaire.

REPORTING CLINICIAN

1. APSU Dr Code/Name ☐☐☐☐ /……………………. 2. Month/Year of Report…..… /………

PATIENT

3. First 2 letters of first name ☐☐ 4. First 2 letters of surname ☐☐
5. Date of Birth: ☐☐ /☐☐/☐☐ 6. Sex M☐ F☐
7. Postal code ☐☐☐☐
8. Date of diagnosis ☐☐ /☐☐/☐☐ 9. Questionnaire completed ☐☐ /☐☐/☐☐

If this patient is primarily cared for by another physician who you believe will report the case, please complete the questionnaire details above this line and return to APSU. If no other report is received for this child we will contact you for information requested in the remainder of the questionnaire.

Please keep the patient's name and other details in your records.

Instructions: Please answer each question by placing a tick in the appropriate box or writing your response in the space provided. DK=Don't Know, NA=Not Applicable

PATIENT HISTORY

9. Is this the first episode of a conversion disorder? ☐ Yes ☐ No ☐ DK
   If no, how many previous episodes?…………………………………

10. Is there a history of previous or current other psychiatric illness in this child? ☐ Yes ☐ No ☐ DK
    If yes, please describe. (e.g. depression, anxiety, school refusal)…………………………………………...
…….

11. i. Is there a history of medical illness in this child? ☐ Yes ☐ No ☐ DK
    If yes, what is the diagnosis? (*Eg* epilepsy) ……………………………………………………………..
…….

11.ii. Has the child reached menarche? ☐ Yes ☐ No ☐ DK ☐ NA

12. Please indicate if either of the following descriptions of personality and behaviour apply to the child.

    ☐ perfectionistic /high achieving ☐ difficult / behaviour problems ☐ NA

FAMILY HISTORY DETAILS

13. Is there a history of psychiatric illness (including conversion disorder) in any immediate family member ☐ Yes ☐ No ☐ DK
    If yes, which family member is affected? ………………………………………………………………
    What is the psychiatric illness? ……………………………………………………………………………..

14. Is there a history of medical illness in any immediate family member? ☐ Yes ☐ No ☐ DK
    If yes, which family member is affected? ………………………………………………………………
    What is the medical illness? …………………………………………………………………………….

15. Please indicate if any of the following descriptions apply to the family.
    a. seemingly harmonious ☐ Yes ☐ No ☐ DK ☐ NA
    b. relationship difficulties (eg conflict, family violence) ☐ Yes ☐ No ☐ DK ☐ NA
       If Yes to 15 b, please detail ……………………………………………………………………..…
    c. chaotic (eg disorganised caregiving) ☐ Yes ☐ No ☐ DK ☐ NA
       If Yes to 15 c please detail ……………………………………………………………………………...

CLINICAL DETAILS

16. What was the duration of symptoms prior to diagnosis?
☐ <1 week ☐ ≥1week to<1 month ☐ ≥1 month to<6 months ☐ ≥6 to < 12 months ☐ ≥ 12 months

17. Has the child experienced a major life stress or chronic stress? (e.g separation or loss of relative, sexual abuse) ☐ Yes ☐ No ☐ DK

If yes, please describe…………………………………………………………………………………………….
…….
…….

18. Please indicate which of the following symptoms or signs were present at the time of diagnosis.

a.Pseudoseizure ☐ Yes ☐ No ☐ DK

b.Motor weakness ☐ Yes ☐ No ☐ DK please describe site ……………………………………………..

c.Paralysis ☐ Yes ☐ No ☐ DK please describe site ……………………………………………..

d.Abnormal gait ☐ Yes ☐ No ☐ DK please describe ……………………………………………………..

e.Abnormal movements ☐ Yes ☐ No ☐ DK please describe ……………………………………………………..

f.Pain ☐ Yes ☐ No ☐ DK please describe ……………………………………………………..

g.Fatigue ☐ Yes ☐ No ☐ DK please describe ……………………………………………………..

h. Anaesthesia/paraesthesia ☐ Yes ☐ No ☐ DK please describe ……………………………………………..….

i.Hearing disturbance ☐ Yes ☐ No ☐ DK please describe……………………………………………………

j.Visual disturbance ☐ Yes ☐ No ☐ DK please describe……………………………………………………

k. Abnormal/Loss of speech ☐ Yes ☐ No ☐ DK

l.Dysphagia ☐ Yes ☐ No ☐ DK

m.Vomiting ☐ Yes ☐ No ☐ DK

n.La belle indifference (e.g. lack of concern in the child about severity of symptoms/signs) ☐ Yes ☐ No ☐ DK

o.Psychogenic cough ☐ Yes ☐ No ☐ DK

p. other (please specify) ……………………………………………………………………………………………………….

INVESTIGATIONS

19. We are interested in the range of investigations performed in children with Conversion Disorder. Please indicate if any of the following investigations were performed.

a. EEG ☐ Yes ☐ No ☐ DK

b. Nerve conduction ☐ Yes ☐ No ☐ DK

c. MRI ☐ Yes ☐ No ☐ DK

d. CT scan ☐ Yes ☐ No ☐ DK

e. EMG ☐ Yes ☐ No ☐ DK

f. Video telemetry ☐ Yes ☐ No ☐ DK

g. Blood tests e.g. Full blood count, ESR, serology, please provide a brief list…………………………………

……

h. Other………...

MANAGEMENT

20. Did the child require admission to hospital? ☐ Yes ☐ No ☐ DK

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

21. Were psychotropic medications prescribed for a co-morbid psychiatric disorder? ☐ Yes ☐ No ☐ DK ☐ NA

If yes, specify medication(s) ………………………………………………………………………………….

22. Please indicate which of the following health professionals have been involved in the patient's care.

General Paediatrician ☐ Yes ☐ No ☐ DK

Psychiatrist ☐ Yes ☐ No ☐ DK

Occupational therapist ☐ Yes ☐ No ☐ DK

Psychologist ☐ Yes ☐ No ☐ DK

Paediatric neurologist ☐ Yes ☐ No ☐ DK

Physiotherapist ☐ Yes ☐ No ☐ DK

Social worker ☐ Yes ☐ No ☐ DK

Other, please specify. ………………………………………………………………………………………

Please return this questionnaire in the addressed reply-paid envelope.
***Thank you for your help with this research project*.**