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The medical history in child and adolescent psychiatry

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ABSTRACT

Introduction: The training of future specialists in child and adolescent psychiatry involves the acquisition of the skills required for interacting with the patient, their parents and teachers. These techniques help to direct the anamnesis within in structured manner which focuses on achieving, as early as possible, a proper diagnosis and treatment.

Objetives: 1) To describe the medical history model we have used in our clinical practice during initial consultations with children and adolescents, and to contribute to the design of a common framework to be used by specialists of child and adolescent psychiatry. 2) To analyze the diagnostic and therapeutic results obtained by retrospectively reviewing clinical histories taken using the same medical history model presented.

Materials And Methods: In relation to the materials used, our medical history model and a school report form are described in detail. With regards to the methodology, we reviewed the medical histories of 147 patients who were attended to over a period of time spanning from November 2007 and April 2008 by the child and adolescent mental health team at the Arganzuela Mental Health Center in Madrid. To evaluate the systematic model of questions and answers that we present, we have compared the results obtained for variables related to the psychiatric diagnosis, treatment and coordination with the patients' schools with those reported in recent literature.

Results: In 80 patients (54.4%) we observed difficulties in adapting to stressful situations, where 66 individuals (44.8%) were diagnosed with Adjustment disorder and the other 14 with Post-traumatic stress disorder (9.5%). Attention deficit disorder with hyperactivity (ADDH) was diagnosed in 36 patients (24.4%) and Conduct disorder in another 14 (9.5%). Depression was recognized in 31 cases (21%) and Anxiety disorder in 23 (15.6%). Treatment was psychological in 144 cases (97.9%), pharmacological in 68 (46.2%), social in 25 (17%) and educative in 144 children and adolescents (97.9%). A request for a school report was made for all of the patients included in the sample. As each school report was sent back, a coordination meeting was set up with the teachers associated with 113 cases (76.8%).

Conclusions: 1) The protocols referred to in this work have proven to be effective at facilitating diagnose, treatment and prevention in childhood and adolescent mental health. Coordination with schools helps to teach the essential skills needed for child psychiatric work within a community.

KEYWORDS: Child and adolescent psychiatry; anamnesis; medical history; school health programs; Social and Community Psychiatry.

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HISTORIA CLÍNICA EN PSIQUIATRÍA INFANTO-JUVENIL

RESUMEN

Introducción: La formación de los futuros especialistas en psiquiatría infanto-juvenil necesita el aprendizaje de técnicas específicas de interacción con el paciente, sus padres y profesores que ayuden a focalizar la anamnesis dentro de un marco homogéneo encaminado a conseguir, cuanto antes, un diagnóstico y un tratamiento adecuados.

Objetivos 1º Mostrar el modelo de anamnesis que hemos usado habitualmente en primeras consultas de niños y adolescentes, a lo largo de nuestra práctica clínica, para colaborar en un diseño curricular común de la especialidad. 2º Analizar los resultados diagnósticos y terapéuticos obtenidos al revisar, retrospectivamente, historias clínicas realizadas con el mismo modelo de anamnesis que se presenta.

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Material y método: En relación al material utilizado, se describe, pormenorizadamente, nuestro modelo de anamnesis y de coordinación escolar. En relación a la metodología, hemos revisado 147 historias clínicas de pacientes atendidos, previamente, con el mismo modelo de anamnesis, durante el periodo de noviembre del 2007 a abril del 2008, por el equipo de salud mental infanto-juvenil del CSM Arganzuela de Madrid. Para valorar el modelo sistemático de preguntas y respuestas que presentamos, hemos comparado, con la bibliografía reciente, los resultados de las variables de diagnóstico psiquiátrico, tratamiento y coordinación escolar de la muestra.

Resultados: Respecto al diagnóstico, en 80 historias clínicas (54,4 %) se observaban dificultades de adaptación a situaciones estresantes del entorno, coincidiendo 66 casos con trastorno adaptativo (44,8 %) y otros 14 con trastorno por estrés postraumático (9,5 %). El trastorno por déficit de atención e hiperactividad (TDAH) se daba en 36 pacientes (24,4 %) y el trastorno de comportamiento (TC) en 14 (9,5 %). El trastorno depresivo se confirmaba en 31 casos (21 %) y el trastorno de ansiedad en 23 (15,6 %). Respecto al tratamiento, la intervención había sido psicoterapéutica en 144 casos (97,9 %), farmacológica en 68 (46,2 %), social en 25 (17 %) y educativa en 144 niños y adolescentes (97,9 %). Respecto a la coordinación escolar se realizaron entrevistas en el centro académico, con los tutores de los pacientes, en 113 casos (76,8 % del total).

Conclusiones: 1ª Los modelos de anamnesis referidos en este artículo muestran su utilidad para precisar el diagnóstico, el tratamiento y la prevención en salud mental infanto-juvenil. 2ª Nuestras actividades de coordinación escolar enseñan habilidades imprescindibles para el trabajo psiquiátrico comunitario.

PALABRAS CLAVE: Psiquiatría infanto-juvenil; anamnesis; historia clínica; coordinación escolar; salud mental comunitaria.

Ethical and legal aspects: We acted according to current legislation guaranteeing the confidentiality of the information as referred to in the Organic Law 3/2018, of December 5, on personal data protection and the guarantee of digital rights.

INTRODUCTION

The transition from childhood and adolescence is a critical period for the subsequent development of psychiatric disorders which can be studied from the perspective of *internalizing* (Psychosomatic, Anxiety and Depression disorders) and *externalizing* (Disruptive, Impulsive-control and Conduct disorders) psychopathological frameworks (McElroy et al., 2018[1]). Associations between psychiatric symptoms, which are observed during this stage, could be the basis that constitute a diagnosis later on in adulthood. Consequently, it is therefore the child and adolescent psychiatrist who can help to prevent disorders from progressing by focusing on the mental health and environments of their patients (Schaefer et al., 2017[2]). The classification of mental illnesses in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), in order to allow its clinical usefulness, is organized according to the age of onset of each disease. Childhood is characteristic of the first diagnostic group followed by adolescence, and then a third group that involves transitioning into adulthood (American Psychiatric Association (APA), 2013. p. 13[3]). In the prevention of the development of psychopathologies in adults, it is important that all children and adolescents with mental health problems receive systematized care using the best possible resources including interventions related to their school environment (O´Connor et al., 2018[4]; Mulraney et al., 2019[5]).

The increase in access to psychiatric treatment occurring over the last three decades has not resulted in a significant decrease in the prevalence of mental illness, which has led to the review of diagnostic and therapeutic methods (Jorm et al., 2017[6]). Epidemiological studies have revealed that approximately 20% of the child population worldwide suffers from some form of psychopathology (Franco & Arango, 2004[8]; Arango et al., 2013[9]; Schaefer et al., 2017[2]; Carballal Mariño et al., 2018[7]; Mulraney et al., 2019[5]). However, accurately measuring the prevalence of mental disorders is a complex task owing to the educational and practical training and resources required to make psychiatric diagnoses and the denial that can sometimes arise (Carballal Mariño et al., 2018[7]). The current more dimensional perspective, which is proposed in the DSM-5 (APA, 2013. p. 12-13[3]), agrees with our proposal for providing specialists with the tools for measuring the presence or absence of psychiatric symptoms, and their severity, which would allow them to make a diagnosis at the precise point within the developmental gradient of a possible mental illness. Also, the high occurrence of comorbidity in childhood and adolescence has forced new variables or risk factors, such as the presence of trauma, mental illness in parents or a dysfunctional family, to be included in the qualitative and quantitative assessment of psychopathology (Doyle, Murphy & Shevlin, 2016[10]).

From a practical point of view, it is accepted that most pediatric specialists have access to the instruments for carrying out extremely objective descriptions of the symptoms of mental illness; however, in the case of child and adolescent psychiatry this procedure still needs to be improved (Arango et al., 2013[9]). For example, if a patient consults a doctor regarding abdominal pain during digestion, the doctor would ask if the pain radiated to the left side or to the right. In contrast, in psychiatry, or in the case of a behavioral alteration that was not considered to be normal, the questions asked would not be so specific. It then becomes necessary to a use a structured

method of assessment that would assist the specialist to arrive at a correct diagnosis.

Evidence-based medicine has shown that pediatric mental health is supported by three basic pillars, health, education and family, which must be coordinated for their proper functioning (Murray-Swank AB & Dixon, 2004[12]; Arango et al., 2013[9]; Doyle, Murphy & Shevlin, 2016[10]; O´Connor et al., 2018[4]; Mulraney et al., 2019[5]; Nguyen et al., 2019[11]).

The influence that parents have on the development of their child's brain has been clearly shown in studies that have proven how variations in parental behavior produce neurobiological changes that can have an impact on a child's health or disease (Simmons et al., 2017[13]). Also, the relationship between parents and teachers can be reinforced through psychoeducational programs that aim to improve the connection between all actors involved including the patient (Murray-Swank & Dixon, 2004[12]). The participation of a school's guidance department in the care and follow-up of students with mental disorders is always essential and involves specific particularities for each pathology (Arango et al., 2013[9]).

Teachers can collaborate in the detection of disorders and participate in the identification of the symptoms manifested within a school context such as in Attention Deficit Hyperactivity Disorder (ADHD) which is a disease that affects at least 5% of the child population worldwide (Franco & Arango, 2004[8]; Wolf, Simkowitz & Carlson, 2009[14]; Nguyen et al., 2019[11]). The existence of disruptive behaviors other than ADHD, such as Oppositional defiant disorder (ODD), the Conduct disorder (CD) and the Impulse-control disorder (ICD), make up the *externalizing* dimension of a psychopathological study (McElroy et al., 2018[1]; Kendler et al., 2018[16]; Andrade et al., 2019[15]). With regard to the *internalizing* dimension, Anxiety disorders and depression also constitute an independent or comorbid psychiatric pathology, which in childhood and adolescence are the targets of preventive measures (McElroy et al., 2018[1]; Rouquette et al., 2018[17]). Adjustment disorders and Post-traumatic stress disorders form part of the *internalizing* aspect of which they complete (O´Donnell et al., 2016[18]; Lewis et al., 2019[19]). In the DSM-5 (APA, 2013[3]), Trauma and stress-related disorders have been grouped together in the same chapter so as to facilitate the study of Adjustment disorder, one the less studied disorders in psychiatry (O´Donnell et al., 2016[18]). From the perspective of how these disorders are understood, we must consider that trauma is defined as a vital threat to a person or their loved ones, while the pain or anguish produced by the stressful event depends on the particular response of each patient and is linked to their own ability to cope with adversity (Deighton et al., 2019[20]). Exposure to severe psychotraumas, such as childhood sexual abuse, has resulted in an increase in the psychotic experiences suffered by adults (2019[21]; Bell et al., 2019[22]).

In this article we propose the use of structured interviews as part of the medical history, with the aim to help professionals throughout the diagnostic process and with the communication that takes place within family and school contexts. Interest in creating a multidisciplinary intervention approach, gathering all fields involved in the treatment of mental illness, is clear in our field (Salagre et al., 2019[23]). Moreover, the use of structured interviews has been proven to be an effective and valid tool for obtaining and quantifying information in child and adolescent psychiatry for more than 25 years (Hodges, 1993[24]; Cerel & Fristad, 2001[25]; Renou et al., 2004[26]; Koposov et al., 2017[27]). The means for collecting clinical data can include different interviewing styles which are best suited to the patient's needs (Boyle et al., 1997[28]; Costello, Egger & Angold, 2005[29]). Our proposal is based on using the medical history to gather information in a systematic way that helps the interviewer to determine, from the first consultation, the approach required for addressing child and adolescent psychopathology. Over the past 40 years, in child and adolescent psychiatry, work has been done to create a systemized method for anamnesis, which can be used in psychiatric training (Arango et al., 2013[9]). Also, clinical data can be obtained through our school report provided by the child's teacher which is collected by the parents. This information constitutes the first step in the coordination of the psychoeducational work used in the prevention of child and adolescent mental health issues within a community (Bains et al., 2017[30]).

MATERIALS AND METHODS:

A) The material used includes our proposed method for anamnesis (Annex 1), which has been described, and our protocol for carrying out the school report (Annex 2).

The medical history is initiated by gathering personal information about the patient and their family, as well as data provided by the child's school. Then, the origin or the type of the patient is described: *external* or outpatient (E), *external interconsultation*, consultation between an outpatient and a specialist from another area (EIC), *internal interconsultation*, consultation between an inpatient and a specialist from another area (IIC) and *inpatient* or person admitted to a psychiatric unit or hospital (I). Once the type of patient has been determined, the extra- or intra-hospital situation of the consultation is explained. The origin of the *extra-hospital* referral can arise from 6 different sources: 1) on the recommendation of the local pediatrician; 2) on the parents' or the patient's own initiative; 3) referred by the educational center through the pedagogical orientation team (Early Help Teams [EHT], primary education orientation teams [PEOT] and High School Counseling Departments [HSCD]); 4) referred by Social Services; 5. by a legal guardian and 6) by direct consultation from another source. The origin of the *intra-hospital* referral can come from the pediatric department or from other specialties.

In addition, the *waiting time*, which is the time between the date of the referral issued by the pediatrician and the date of the psychiatric consultation, and *time of evolution*, the time elapsed since the onset of the symptoms until the psychiatric consultation, are measured.

The *reason for consultation* (RC) is described from three perspectives: a) the information determined in the inter-consultation by the referral specialist; b) the parents' reasoning for wanting the consultation and c) the interpretation of the information obtained in this first consultation or "*reformulation of the demand*" by the professional attending the patient. It should also be specified whether the RC has been previously established or not.

While the parents or guardians are being interviewed about the *current disease* (CD), the patient is asked to take a *drawing test about the family*, real or imaginary, which will subsequently be examined individually following the indications of Louis Corman (1982)[31].

The analysis of the CD begins with a literal description of the events that have led to the consultation and continues with a list of symptoms, as described by the parents, following the proposed medical history model and put into context by a list of questions aimed at clarifying the diagnosis (Table 1).

The first group of questions in the analysis of the CD refers to ruling out ADHD following the diagnostic criteria of the DSM-5 (APA, 2013[3]). If the parents answer by saying that the child is restless, we try to reveal whether the restlessness or motor activity is greatly exaggerated; that is, whether they would label the patient as a "rambunctious child" because he or she was prone to having accidents or tries to cross the street without looking. The second question regarding the symptoms of a possible case of ADHD is to ask "is the child absent-minded or overly distracted? This can be formulated in terms of whether "he doesn't seem to listen when you talk to him", he is seen as "being unenthusiastic with regard to almost everything"; and, when he comes home, you have to do his homework with him, because if not, "he would never finish it". In addition, "he doesn't bring his homework with him", and he is often forgetful and easily distracted. Also, with regard to the possibility of ADHD, impulsivity can be measured in terms of "how the child usually talks, answers or intervenes " in his conversations with his parents.

Tabla 1 Possible questions for parents to help guide the medical history

1. ADHD Symptoms	Is the patient restless or rambunctious? Does he have or has he had many accidents? Does he cross the street without looking? Does he think before he speaks or does he speak impulsively? Does he seem not to listen when you talk to him? Does he forget about his homework? Does he forget his wallet, and other things? Does he require someone to study with him? Is he easily distracted? Does he attend class?
2. Oppositional Defiant Symptoms	Is he disobedient? Is he the type to say "no" to everything and then say, "let's talk about it later"? Do you have to ask many times for him to do things? Is he mad at the entire world? Does he misbehave? Does he reflect on the consequences of his actions?
3. Depression Symptoms	Is he happy or sad? Does he not feel like doing the usual fun activities? Does he complain about being tired or having no energy? Does he get irritable for no reason? Does he say negative things about himself? Does he say negative things about life? Does he cry often?
4. Anxiety Symptoms	Does he worry about everything? Is he afraid? Has he had many big scares in life? Does he have any reoccurring concerns? Is it hard for him to go to school? Does he face or avoid the feared situation? Does he have any "fixations" or obsessions?
5. Socialization Problems	Does he have friends? Does he meet with them? Does he have problems expressing himself? Does he have problems with classmates? Is he being bullied, or has he ever been bullied? Does he have difficulties interacting with others?
6. Eating or Sleeping Problems	Does he eat poorly? Does he eat too little, follow diets, eat too fast? Does he eat uncontrollably, throw up? Does he sleep poorly, have nightmares, not sleep enough. Does he fall asleep in class?
7. Problematic Behavior with Video Games/ Internet	Does he spend a lot of time playing video games or on the internet? Is he unable to know when to stop? Does he get really angry if it is taken away? Does he engage in other risky behaviors?
8. Difficulties at School	What do the teachers think of him? Does he attend class? Is he restless? Is he shy? How does he relate to others? Has he ever seen a school counselor? What are his grades like?

The second group of symptoms as described in Table 1, which indicate the tendency toward oppositional conduct, are approached by asking "is your child obedient or disobedient" and are formulated using the following question: "does the patient frequently do the opposite of what you ask?" If the answer to this question is affirmative, it would be followed by: "is he or she the type to say 'no' to everything and then say let's talk about it later?" or "do you have to ask many times for him to do things? "Is he mad at the entire world?" "Does he misbehave and unable to tolerate even the slightest level of frustration?" "Does he find it difficult to wait for rewards?" "Is he unable to reflect on the real consequences of his actions?" When serious problems of oppositional conduct are detected, it becomes necessary to specify the existence of any behavior-

al problems. It is well known that behavioral problems occur in children who are lacking proper emotional control, which is subsequently reinforced by parents with violent behavior (Darella et al., 2019[32]).

The group of depressive symptoms listed in Table 1 start by asking "Are you sad?" and by the observations made by parents with regard to if the child frequently cries or makes "negative comments about themselves, about life or about their own body". These questions are aimed at exploring, in general, the concepts of self-esteem and to identify any possible negative verbal expressions such as "life is not worth living" or the presence of thoughts, threats or attempts of suicide. The anamnesis of the depressive symptomatology can be completed by including comments like "he doesn't feel like doing activities that require the smallest amount of motivation", "he always complains about being tired and having no energy" or "he gets irritable for no reason ".

In order to expose symptoms of anxiety, the parents can follow two lines of questioning that, in the analysis of the CD, are specified as "Is he afraid?" or "Does he have many concerns?" Also, it is necessary to value the intensity of the fear, its lack of justification and avoidance behaviors toward feared situations in order to determine the presence of phobias, like those associated with school. In the event that the parents confirm the existence of excessive worrying, it should be clarified whether these worries occur with all types of activities or have a specific cause. For example, the worry caused by the fear of losing eye contact with them, which could lead to a diagnosis of separation anxiety during childhood (Silove et al., 2015[33]). An interesting aspect to consider is whether the excessive worrying is associated with the onset of obsessions or "fixations". Moreover, it is the parent's responsibility to identify what they suspect to be the plausible psycho-traumatic cause for their child's fears and uncertainties.

The problem of socialization listed in the analysis of the CD is evaluated using questions such as "Does he have friends?" "Does he have fun with his friends?" "Does he relate well to his classmates?" "Is he being bullied, or has he ever been bullied? Any communication and interaction issues will be specifically assessed if social relationships are disrupted using questions such as "Does he have language difficulties?" or "Does he find it difficult to interact with others?" The presence of psychotic symptoms is explored when the patient "sees and hears things that others do not see or hear", which is usually in the context of difficulties with social interactions.

The following questions regarding the CD involve self-care issues that are expressed through eating and sleeping behaviors. If the initial response indicates there is a problem, certain questions are used to open up a wider range of possibilities. For example, if the parents respond that the patient doesn't eat well, they will be asked if the child eats very little, excessively or in an uncontrolled manner. With respect to sleeping habits, the parents will be asked whether their child sleeps badly or for only a few hours and if these problems affect their quality of life.

Section 7 of Table 1 focuses on detecting problematic and high-risk behavior with regard to video game and internet use. The questions asked are "Does he spend a lot of time playing?" "Is he unable to know when to stop?" "Does he get really angry if it is taken away?" "Does he always get irritable if he is unable to play?" In addition, the number of hours spent playing should be recorded so as to examine to what extend the patient is affected and also how he progresses. Also, identifying the existence of other problematic risk or addictive behaviors is useful in their prevention.

The final set of questions put forward to the parents in the analysis of the CD explore the opinions the teachers have transmitted to them about their child: "Is he attentive and motivated in class?" "Is he restless?" "Is he shy?" "How does he relate to his classmates and teachers?" "Was he evaluated by the team of school counselors?" "What are his grades like?" "Is he happy during recess?"

Information regarding the child's *Personal history* (PH) and *family background* (FB) is collected in the corresponding sections of the medical history in a systematic and schematic way (Annex 1).

In our medical history model, the *clinical exploration* (CE) is a process that is always carried out in the presence of the parents, except when the patient himself, especially in the case of adolescents, requests to be interviewed individually. Owing to the high prevalence of ADHD (Martínez-Martin et al., 2015[34]), we recommend that while the patient is being interviewed the parents fill out the Magallanes Screening Scale for Attention Deficits and Other Developmental Problems in Children (EMA-DDA, parents) as a "screening" questionnaire (García & Magaz, 2000[35]). Initially, as a means to assess their concept of self-esteem, the patient is asked to rank, using the scale offered, how "smart", "happy" or "athletic" (Appendix 1) they consider themselves to be. The RC is noted according to the patient's opinion and his or her tastes and hobbies. At the same time it is specified whether their tastes or hobbies have a negative effect on the patient's quality of life, are stereotyped or constantly repeated without any variation and in a paroxysmal way. It is extremely important to analyze their peer social networks, if they have friends and who these friends are, as well as if they are being mistreated by any of them (specifying if this situation could be classified as bullying) and if, in general, they have good relationships with their peers.

Following on, the patient is asked to discuss the drawing he or she made of the "*real or imaginary family*". This procedure takes place while the parents are answering questions about the CD. This evaluation procedure consists of two parts: first, the description provided by the child or adolescent regarding their drawing is literally transcribed; then, an associative questionnaire is completed based on the questions proposed in the family test designed by Louis Corman (Corman, 1981[31]). Several questions are asked about the characters represented in the drawing: Are they happy? Is everyone the same? Is there anyone who is more or less happy than the others? Are they all good or is anyone better or worse than the others? Do they play "pranks" at home? Who is the person who played the prank and what was the reaction of the parents?; and, finally, "If they were to go on a trip, would they all go together, or would someone stay at home?"

A crucial aspect that should be noted is whether the patient cries during the interview and how they respond to the techniques used to comfort them. The patient's self-esteem is also explored by checking if they have negative thoughts about themselves, about life or about their own body. It is also interesting to discover what they consider to be their ideal life and their expectations for the future by asking them "What do you want to be when you grow up?" and "What are your three top wishes?"

An assessment of the writing is done by analyzing both the text written by the patient regarding their *three wishes* and the *family drawing*. Moreover, their short-term attention span is measured through an age-appropriate inverse numerical series of 3, 4, 5, and 6 or more digits. Likewise, an evaluation is carried out while they read aloud a text specifically chosen for all patients, focusing on fluency, decoding and reading comprehension.

The results of the EMA-DDA (parents) screening questionnaire, which the parents are asked to take at the beginning of the analysis of the CD, with differentiated scores regarding impulsivity, inattention and hyperactivity (García & Magaz, 2000[35]) are incorporated in the corresponding section of the model (Appendix 1).

The particular observations of the professional conducting the interview are gathered with respect to how they have assessed the patient's functional impairment, whether he or she is concerned about the situation, whether he or she has detected that the child is nervous or restless during the interview and, finally, whether they have been able to increase the child's motivation with respect to getting better.

Finally, when necessary, it is recommended that other questionnaires are include in the assessment that may be useful for reaching a diagnosis. For example, in our model (Annex 1) we include the State-Trait Anxiety Inventory ("self-evaluation questionnaire) or STAI (Spielberger, 2019[36]) to measure the levels of anxiety and adaptation to stress and the Leyton Obsessional Inventory-Child Version or LOI-CV (Canals et al., 2011[37]) to identify Obsessive compulsive disorders or OCD from obsessive behaviors.

After recording the observations that are considered relevant, all information requested from other services, whether psychological or medical, is collected (Annex 1).

The diagnosis is based on suspicion and is carried out according to the five axes usually used in child and adolescent psychiatry:

- Axis I: Psychiatric illness.
- Axis II: Problems in development and learning.
- Axis III: Associated medical illness.
- Axis IV: Previous stressful events.
- Axis V: Patient's functioning during the year prior to the consultation.

The psychiatric diagnoses is formed from the first two axes and is completed using the information collected from the remaining axes (APA, 2013[3]).

Next, using our medical history model (Annex 1), it is noted whether or not the protocol for requesting a school report (Annex 2) is going to initiated. This is done after the parents have given their informed consent, which is essential for the exchange of data between mental health services and educational centers. For most patients a school report is requested, unless the patient is discharged or referred to another clinical service after the first consultation.

The different therapeutic interventions are listed in the corresponding section (Appendix 1): Drugs, psychotherapy, application for support from Social Services and Family (FHC) or Child (CHC) Help Services, application for admission to an Adolescent Unit or for admission to an Emergency Room and request for a consultation with a child neurologist or other specialists.

The section on coordination with schools in Annex 1 starts with the results of the school report (Annex 2). Depending on the conclusions drawn from these data, it is then assessed whether it is necessary to ask the patient's teacher to complete the ADHD "screening" questionnaire (EMA-DDA, school) (García & Magaz, 2000[35]) or if there is a need to arrange a meeting with the counseling service and the patient's teachers.

B) With respect to the methodology used, we would like to point out that over the last 35 years we have used the specific medical history model specified in Annexes 1 and 2 in our clinical practice. Using a retrospective study, we reviewed the medical histories of 147 patients who were attended to over a period of time spanning from November 2007 and April 2008 by the child and adolescent mental health team at the Arganzuela Mental Health Center (Arganzuela MHC) in Madrid. This approach allowed us to recover all of the questions comprising the medical history model, which we applied to all patients during the first consultation (Annex 1).

By examining the 147 medical histories we were able to study the socio-demographic variables; the reason for the consultation (by comparing the content of the inter-consultation report and the "reformulation of the demand"); the waiting time; the evolution time of the symptoms being investigated; the origin of the interconsultation report and the demand for referral; the personal psychiatric and medical history; the family psychiatric history; any previously experienced stressful events; the suspected psychiatric diagnoses according to the DSM-5 (APA, 20133); the professionals at the Arganzuela MHC who had attended the patient during their first consultation; the therapeutic methods used; and the interventions carried out through coordination with the patient's school. The detailed results of all the variables studied are shown below.

RESULTS

The 147 patients, seen for the first time at the child and adolescent unit of the Arganzuela Mental Health Center during a 6-month period, were distributed as follows: 84 males (57.2%) and 63 females (42.8%), with ages ranging at the time of consultation between 18 months and 17 years (average age: 10 years and 3 months).

There were 95 ordinary and 52 preferential consultations with an average waiting time of 13.8 days (interval: 1-28 days). The average time of symptom evolution was 9 months (interval: 5 days-3 years).

The *interconsultation* originated from an early childhood intervention team in 134 of the cases (91.2%), from the emergency department on 5 occasions (3.4%), from hospital discharges in the cases of another 5 patients (3.4%); and, finally, from 3 direct consultations without an appointment (2%).

A *demand for referral* had been made by either a pediatrician or a local primary healthcare physician in 116 cases (79.1%). For 16 patients, a request for care had originated from the parents (10.8%) while in 12 cases (8.1%) the demand came from local schools and psychopedagogical intervention teams; and 3 adolescents (2%) had sought help on their own initiative.

Figure 1 Comparison between the reasons for consultation (RC) determined during the *reformulation of the demand* by the psychiatrist and those determined by the pediatrician.

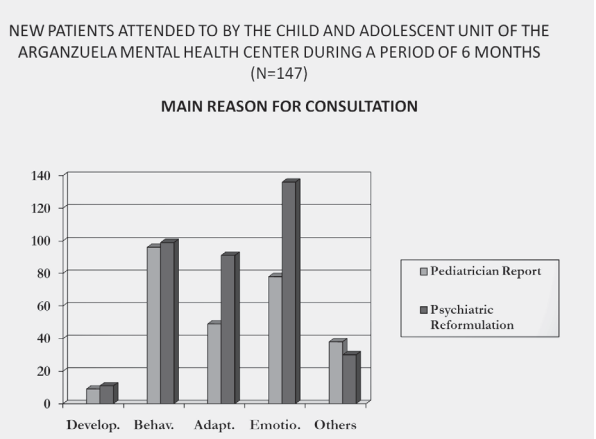

Figure legend: Emotional and adjustment problems are more frequently determined as being the reason for consultation (RC) by the psychiatrist, in the reformulation of the demand, than by the pediatrician. In the case of behavioral and developmental problems this difference was not as marked.

The *reason for consultation* (Figure 1) that was most frequently observed in the *reformulation of demand* was related to emotional problems (136 patients, 92.5%), followed by behavioral problems (99 patients, 67.3%), adaptive difficulties (91 patients: 61.9%) and developmental difficulties (11 patients, 7.4%). In the *consultation reports*, the most frequent reason for consultation was related to behavioral problems (96 patients, 65.3%) followed by emotional problems (78 patients: 53%), adaptive difficulties (49 patients, 33.3%) and developmental difficulties (9 patients, 6.1%).

Personal history of psychiatric illness was recorded for 80 patients (54.5%). For 49 cases (33.3%), the previous consultations had been with a psychologist, 8 (5.4%) with a psychiatrist, and for 23 patients (15.6%) the consultations that had been with both specialists.

Personal history of somatic disease appeared on 35 occasions (23.8%). There were previous hospital admissions in 67 cases (45.5%) and a surgical history in 41 cases (27.8%).

Family psychiatric antecedents were found in 95 cases (64.7%). In 58 cases, the persons affected were first-degree relatives (39.4%), 14 were second-degree relatives (9.5%) and the remaining 23 cases had both first- and second- degree relatives with psychiatric histories (15.6% of the total). Figure 2 shows the distribution of family histories based on pathology. With regard to Affective disorders, there were 75 patients with first-degree relatives who had suffered from this type of

Figure 2 Association of psychiatric pathologies according to familial relations

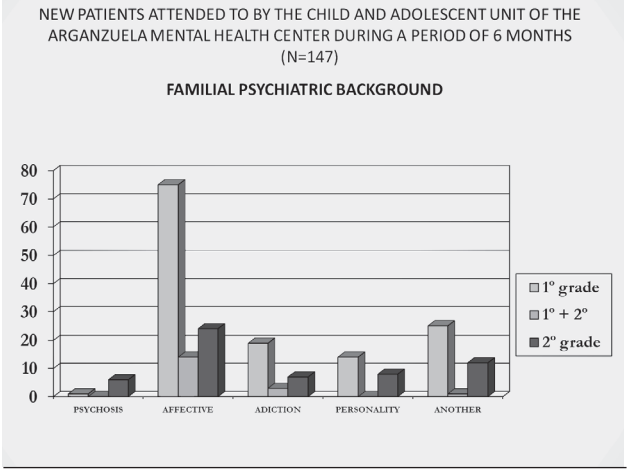

Figure legend: With regard to first-degree relatives, the most frequent psychiatric past histories were associated with Affective disorders, occurring in 75 cases (51% of the total), followed by other psychiatric diseases, such as ADHD occurring in 25 cases (17%), Addictive disorders in 19 cases (12.9%) and Personality disorders in 14 cases (9.5%). For second-degree relatives, Affective disorders were also predominant, in 24 cases (16.3%), followed by ADHD in 12 cases (8.1%), Personality disorders in 8 (5.4%), and Addiction disorders in 7 cases (4.7%). The psychiatric past histories in relatives of both first and second degrees were Affective disorders in 14 cases (9.5%), Addictive disorders in 3 cases (2% of the 147 patients) and ADHD in one case (0.6%).

Figure 3 Most frequent psychiatric disorders diagnosed among the 147 patients

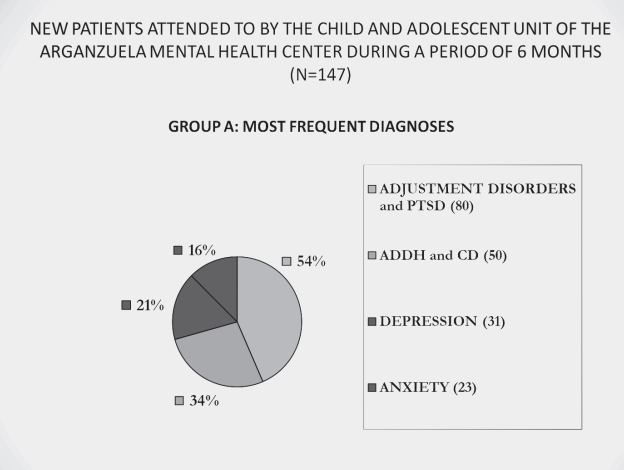

Figure legend. The most frequent disorders were Adjustment disorders and Posttraumatic Stress Disorders (PTSD), which were diagnosed in 80 cases (54.4% of the patients), followed by Attention Deficit and Hyperactivity Disorder (ADDH) and Conduct disorders (CD) in 50 cases (34%), depression in 31 cases (21%) and Anxiety disorders in 23 cases (15.6%).

disorders (51%), 24 with some second-degree relatives (16.3%) and 14 patients with both first- and second-degree relatives with Affective disorders (9.5%). Addictive disorders were present in the first-degree relatives of 19 patients (12.9%), in the second-degree relatives of 7 patients (4.7%) and in both first- and second-degree relatives in the cases of 3 patients (2%). With respect to Personality disorders, they were observed in 14 first-degree relatives (9.5%) and in 8 second-degree relatives (5.4%). Regarding psychoses, there was one first-degree relative with schizophrenia (0.6%) and 5 second-degree relatives with other psychotic histories: 3 with Bipolar disorder (2%), 1 with paranoid psychosis (0.6%) and one with Autism Spectrum disorder or ASD (0.6%). Other psychiatric antecedents, especially ADHD, occurred in the first-degree relatives of 25 patients (17%), in the second-degree relatives of 12 patients (8.1%) and in both first- and second-degree relatives of 1 patient (0.6%).

From the point of view of the impact that stress has on psychiatric pathology, 106 *stressful life events* were found to have been experienced in 91 cases (61.9% of the total). One stressful life event was found in 77 patients (52.3%), two in 13 patients (8.8%) and three in 1 patient (0.6%). Severe parent-child relationship problems were observed on 34 occasions (23.1%) and complicated acculturation processes in 26 cases (17.6%). Jealousy among siblings occurred in 11 cases (7.4%), bullying occurred in 5 cases (3.4%), in 8 cases there was bereavement due to family deaths (5.4% of the total) and nine patients had suffered from somatic diseases causing adaptive stress (6.1%). Two children suffered from child neglect and abuse (1.3%) and 7 more had endured situations of domestic violence (4.7% of the total). Finally, another 4 patients (2.7%) had experienced events as serious as two traffic accidents, a mugging and the 11-M terrorist attack.

In total, among the 147 cases, there were 227 suspected *psychiatric diagnoses* which were classified into two groups: A) the most frequent diagnoses (Figure 3) and B) the least frequent (Figure 4).

The most frequent diagnoses in group A (Figure 3) comprised those related to adaptation to stress, involving 80 cases (54.4%). In addition, 50 patients (34%) were diagnosed with disorders related to ADHD and behavioral problems, 31 with depression (21%) and 23 (15.6%) with psychosis related to anxiety. The 80 diagnoses related to adaptation to stress were associated with 66 patients with an Adjustment disorder (44.8%) and 14 with Post-traumatic stress disorder (9.5%). The 50 diagnoses related to ADHD and behavioral problems were distributed as follows: 36 patients with ADHD (24.4%), 12 with Oppositional defiant disorders (8.1%), 1 with a Dissociative disorder starting in childhood (0.6%) and 1 adoles-

cent who presented antisocial behaviors (0.6% of the total). The 31 diagnoses related to depression were 22 cases of persistent or Dysthymic depressive disorders (14.9% of the total), 8 Post-mourning depressive disorders due to the death of a loved one (5.5%) and 1 major depression (0.6% of the total). Finally, the 23 anxiety-related diagnoses were distributed with 8 patients with simple phobic disorders (5.4%), one case of social phobia (0.6%), 5 disorders of excessive anxiety in childhood (3.4%), 4 with separation anxiety (2.7%), 3 disorders of anxiety without agoraphobia (2%) and 2 Obsessive compulsive disorders or OCD (1.3% of the total).

Group B comprised diagnoses that were less frequently occurring (Figure 4). Fifteen patients were diagnosed as having Eating behavior disorders (ED) (10.2%) which were divided into 10 with bulimia nervosa (6.8%), 4 with Anorexia nervosa (2.7%) and an unspecified ED in the form of obesity (0.6% of the total). Fourteen diagnoses related to learning and maturity development (9.5%) were also found, which were distributed as 5 cases of enuresis (3.4%), 1 case of encopresis (0.6%), 3 cases of patients with language disorders (2%), 2 with mild intellectual development disorder (1.3%), 1 with dyslexia (0.6%), one with dysorthography (0.6%) and 1 with dysphemia (0.6%). Six diagnoses related to impulse control were observed (4%) identified as 2 trichotillomania (1.3%), 2 motor tics (1.3%), a problematic risk behavior of video game addiction and an unspecified Impulse-control disorder in the form of a compulsive scratching pattern (0.6%). Finally, the diagnoses of Reactive attachment disorder, Conversive disorder, Autism Spectrum disorder (ASD), selective mutism, exhibitionism, Factitious disorder by proxy were established, together with a patient affected by cannabis consumption and a patient with chronic insomnia (0.6%, respectively).

The *therapeutic interventions* studied were distributed into three different groups: psychological, pharmacological and social. The treatment was psychological in 61 cases (41.4%), psychological and pharmacological in other 58 cases (39.4%), psychological and social in 15 cases (10.2%) and psychological, pharmacological and social in another 10 patients (6.8%). The remaining 3 patients (2%) were discharged after the first consultation and referred to their local pediatrician without treatment. In summary, 144 patients received psychological or psychotherapeutic treatment (97.9%), 68 received pharmacological treatment (46.2%) and in 25 cases social intervention was carried out (17%).

The professionals comprising the team of child mental health experts that had implemented these treatments were distributed as follows: a child psychiatrist had intervened in 147 consultations; a child psychologist had participated in the treatment of 105 patients (71.4%); and the specialized mental health nurse and social worker attended to 33 cases in collaboration (22.4%).

Figure 4 Least frequent psychiatric disorders diagnosed among the 147 patients

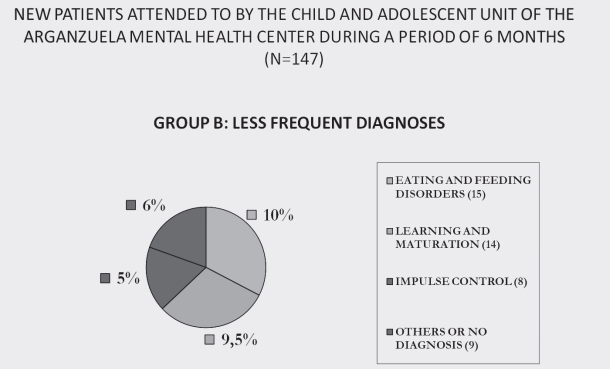

Figure legend: The following disorders were less frequently diagnosed: Eating behavior disorders or ED in 15 cases (10%), learning and maturity problems in 14 cases (9.5%), Impulse control disorders in 8 patients (6%) and another 8 cases involving Reactive attachment disorder, Conversion disorder, Autism Spectrum Disorder (ASD), selective mutism, exhibitionism, Factitious disorder by proxy, a patient affected by cannabis use and another with chronic insomnia. Only one case was left without a diagnosis.

A school report was requested for 144 of the cases (97.9%). Also, based on the information received, the need for a coordination meeting between the patient's teachers and the psychopedagogical guidance team was identified on 113 occasions (76.8%). These meeting always took place at the patient's school so as to promote greater collaboration between mental health and educational services.

DISCUSSION

Most of the content of the proposed medical history model (Annex 1) is difficult to discuss or carry out a comparative analysis owing to the scarcity of similar protocols for conducting a psychiatric clinical history adapted to children and adolescents (Arango et al., 2013[9]; Salagre et al., 2019[23]).

However, we will now review the results obtained from studies analyzing the same variables, in order to contrast the clinical usefulness of the set of questions put forward to the patients and their parents, i.e., those comprised in Annex 1, (Carballal Mariño et al., 2018[7]).

There are no significant differences between the percentage of males and females in our sample of medical records, despite a slightly higher number of males, (57.1%), as occurs for most psychiatric disorders (Kessler et al. 2005[38]). In a recent study, analyzing the prevalence of neurodevelopmental, behavioral and learning disorders in primary health care in

Spain, 68.2% of the patients were male (Carballal Mariño et al., 2018[7]).

This same pediatric study (Carballal Mariño et al., 2018[7]) reports that in more than 90% of the cases, the reason for a request for consultation made by the family, pediatrician or the school is associated with problem detection. In our work, the demand for referral came mainly from pediatricians and family doctors in 78.9% of the cases. As for the origin, it was verified that the interconsultation came from primary health care workers in 91.1% of the total number of cases. These figures reinforce the importance of the need for collaboration between pediatricians, family doctors and child and adolescent mental health services, as early as the first consultation (Arango et al., 2013[9]; Salagre et al., 2019[23]; Duncan et al., 2019[39]; Miettunen et al., 2019[40]).

In our study, behavioral or *externalizing* problems seem to be the main reason for consultation (RC), in particular, interconsultation or referral, making up 65.3% of the total number of RC. After the psychiatric reformulation of the demand, in search of the latent reasons for consultation, the most frequent RC was considered to be emotional or *internalizing* problems in 92.5% of the cases (Figure 1). For some time now, the outcome of requesting psychiatric help for children and adolescents in Spain has been related to a wide-ranging interaction between the presence of *internalizing* or emotional problems vs. *externalizing* or behavioral problems, the latter being the more common reason for consultation (Gómez-Beneyto et al., 1994[41]; Carballal Mariño et al., 2018[7]). Moreover, it is known that the rates of detection with regard to behavioral or *externalizing* problems are quite similar for pediatricians and psychiatrists, emotional or *internalizing* problems are more often detected by psychiatrists (McElroy et al., 2018[1]).

In our sample, 54.4% of the patients had a personal history of psychiatric or psychological consultations. In the study by Carballal Mariño et al. (2018)[7] on primary health care, 42% of patients examined had been assessed for mental health. These high percentages highlight the general need for improving the mental health care of children and adolescents (Duncan et al., 2019[39]; Miettunen et al., 2019[40]).

In the same line of research, which associates the family psychiatric history with the psychopathology of children and adolescents, the importance of achieving, whenever possible, an effective treatment for both parents and relatives to prevent any problems them may have from affecting the children has been considered (Fitzsimons et al., 2017[42]). In 64.6% of the 147 cases studied, first- and second-degree relatives were known to have suffered from mental illness, with Affective disorders being the most common form (48.2% of the total number).

Regarding this, and for the purpose of considering the effect that stressful life events may have on producing an adaptive or psycho-traumatic response, depending on the patient's *resilience* and the intensity of the stress, we collated all adversities appearing in the personal and family histories in our medical records (Appendix 1) (Davydov et al., 2010[43]; McKelvey et al., 2018[44]; Targum & Nemeroff, 2019[45]). Potentially stressful situations were identified in the group of patients studied such as suffering from a chronic somatic disease, being victim to school bullying, suffering from problems within the parent-child relationship, having experienced complicated acculturation processes, jealousy among siblings, mourning for the death of a loved one, child neglect or abuse, situations of intra- or extra-family violence, traffic accidents or having witnessed a terrorist attack. In our study, 91 patients (61.9%) were observed to have experienced one, two, or three of the above-mentioned stressful events. Chronic diseases, complicated acculturation processes and violent situations were present in the medical histories of 39 out of 91 patients. In primary health care (Carballal Mariño et al., 2018[7]), 42 patients, representing 28.8% of the sample, presented a high level of stress, the most frequent being associated with family members, appearing in 35 of the 42 cases. The stressful events referred to by Carbañal Mariño and his collaborators (2018)[7] are related to economic and social problems and parental separation, both associated with excessive family stress, the presence of illness or death of a family member, bullying, abuse and neglect. The identification of most of the possible stressful events for each patient helps to strengthen personal and family *resilience* and increase the prevention of suffering and mental illness in childhood and adolescence (Soutullo & Mardomingo, 2010[46]; Fox et al., 2018[47]).

With regard to group A, comprised of the most frequent psychiatric diagnoses found within our sample (Figure 3), among the 91 individuals who had experienced stressful events, internalizing psychopathologies were observed in 80 patients, with 66 diagnosed as having experienced Adjustment disorder (44.8%) and 14 with Post-traumatic stress disorder (9.5%). Other *internalizing* disorders included the diagnosis of depression in 31 patients (21%) and anxiety in 23 patients (15.6%). In total, the diagnoses of *internalizing* disorders, associated with other diagnoses, or not, was found in 90.9% of the sample. The diagnosis of *externalizing* disorders was present in 50 patients, distributed as 36 with ADHD (24.4%) and 14 with behavioral disorders (9.5%). In the previously mentioned study on primary health care, (Carballal Mariño et al., 2018[7]), the most frequent diagnosis was ADHD which occurred in 46.2% of those exhibiting psychiatric pathology. In addition, they also found that behavioral disorders occurred in 16.2% of the patients. Therefore, the *externalizing* diagnoses established in their study constituted 62.4% of the total number of patients, as compared to 33.9% of patients in our study.

The *internalized* anxiety-depressive disorders diagnosed in the same study reached 20.9%, as compared to 90.9% of the patients in our study. It is uncommon to find in the literature a higher prevalence of the diagnosis of *internalizing* disorders, and *externalizing* disorders are usually more frequent both in and outside of Spain (Gómez-Beneyto et al., 1994[41]; Sawyer et al., 2001[48]; Franco & Arango, 2004[8]; Gómez-Restrepo et al., 2016[49]; Carballal Mariño et al., 2018[7]; Georgiades et al., 2019[50]). It is noteworthy that the appearance of emotional or *internalizing* symptoms in childhood may correspond to the development of behavioral or *externalizing* symptoms in adolescence, and that both are often found to co-exist (McElroy et al., 2018[1]). The structure of the clinical history models used in our study allows the early detection of *internalizing*, adaptive and post-traumatic problems, placing special attention on the percentage of pediatric patients with emotional difficulties, which can complicate their behavior as adolescents in the absence of early intervention.

In group B, comprising the less common diagnoses found in our sample (Figure 4) and included in the section involving 14 cases of patients with learning and maturity problems, 4 patients were found to have language disorders (2.7%) and 2 suffered from specific difficulties regarding literacy (1.3%). In the study on primary health care (Carballal Mariño et al., 2018[7]), 29.7% of patients were diagnosed with language difficulties, and 28.3% with learning disorders. In view of these results, there is a clear need for carrying out preventive work to detect and solve, as early as possible, any problems in maturity development, together with the school services that support pediatric, psychological and psychiatric interventions with mental health issues (Bay et al., 2017[51]). In addition, unspecified eating or feeding disorder, another low-frequency diagnosis found in our study, affected one of our patients in the form of obesity (0.6%). In the study on primary health care (Carballal Mariño et al., 2018[7]), obesity was presented as a chronic pathology in 17 patients (11.6%). Thus, there is a clear need to address the problems related to overweight children, which are currently on the rise and not approached from an emotional perspective that could help improve the prognosis of these children (Kumar & Kelly, 2017[52]; Ajejas et al., 2018[53]). Another infrequently diagnosed disorder, but one of great severity, was Autism spectrum disorder (ASD) which was detected in one patient in our sample. By contrast, in the primary health care study 11 cases were diagnosed (Carballal Mariño et al., 2018[7]). A plausible explanation for this difference in frequency could be that in recent times this pathology is more prevalent. This situation allows ASD to be detected at the level of primary pediatric care, accelerating the process of the psychiatric consultation and direct referral to an ASD unit and the subsequent integration and effective and individualized psychoeducational treatment of the patient (Atladottir et al., 2015[54]; Baio et al., 2018[55]).

From the point of view of therapeutic interventions, in our study psychotherapy was done in 97.9% of the cases and drugs were used in 46.2%. Individual and family psychotherapy was practiced, from the first consultations, with all patients who presented some emotional, adaptive or behavioral problem. In the primary health care study, which we have been comparing our data to, 41.8% received psychotherapy and 32.9% drugs. (Carballal Mariño et al., 2018[7]). The particular structure of the medical history model presented in Annex 1, allows us to design an individualized psychotherapeutic approach for each patient, who will receive, starting from the first interview, a therapy session that provides essential support for improving their progress and prognosis (Kim-Cohen et al., 2003[56]; Kessler et al., 2007[57]; Ramchandani et al., 2017[58]).

The relationship between mental health and education services is usually in the form of coordination with psycho-pedagogical orientation teams; first, to specify and concretize psychiatric diagnoses and second, to support children and adolescents in need at school (Anderson et al., 2003[59]; Power, Tresco & Cassano, 2009[60] Soutullo & Mardomingo, 2010[46]; Arango et al., 2013[9]; Boyle et al., 2019[61]). Of the total number of patients in the primary health care study, 57.5% had been assessed by an orientation team and 33.6% had received school support (Carballal Mariño et al., 2018[7]). However, we propose a new type of intervention, in which the protocol associated with the school report (Annex 2) allows teachers to participate in the diagnostic process in a more personalized and immediate way. A school report request was made for the 144 patients who were not discharged (97.9%), and once each completed report had been received, it was decided, in 76.8% of the cases, to request a coordination meeting with the patient's teacher and the psycho-pedagogical orientation team. It was proposed that the meetings be held at each respective school as a means to promote the involvement of preschools, primary schools and high schools in the joint process of treatment and prevention in mental health care (Dray et al., 2017[62]).

CONCLUSIONS:

1. The application of our medical history model acts as a script that helps develop collaboration between the parents, the patient and the psychiatrist, as a means to obtain the most accurate diagnosis possible.

2. The interview should be conducted in a manner that reinforces doctor-patient bonding, which in turn increases the patient's enthusiasm toward treatment.

3. The systematic combination of questions and answers allows us to create an even view of each clinical case, which will serve for the joint participation of pediatricians and mental health services in the process.

4. The school report protocol allows teachers to participate in the detection of children and adolescents requiring help and foments their collaboration in the continuity of care.

5. Coordination with schools helps to teach the essential preventive healthcare skills required in community-based child and youth psychiatry.

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ANNEX 1: Medical History Form.
Registration Number 16/2015/4962. Dr. José Luis Jiménez Hernández.

Annex 1: Medical History Form.
Registration Number 16/2015/4962. Dr. José Luis Jiménez Hernández.

MEDICAL HISTORY FORM - CHILD AND ADOLESCENT PSYCHIATRY

PATIENT'S PERSONAL DETAILS

Name:..... **Med. Hist. No.**:.....
DATE:..... Age..... **Sex**: M F
Date of birth..... **Weight**:..... (p-)
Height:..... (p-)
Patient Code:……..
Place of birth:……..... **Place of residence**:……..
…… ……

School …… Tel. No. ……..
Address …… Teacher ……

REFERRAL SOURCE

- Type of patient: E EIC IIC I
- Extrahospital: Local Pediatrician:..... Dr.....
Own Initiative..... Professional Association/ Pedagogical Orientation Team
Social Services…… Legal…… Direct Consultation……
Waiting time:.....Time of evolution:.....
- Intrahospital: Pediatrics..... Other specialties.....

REASON FOR CONSULTATION

a/ Interconsultation:……...
……
b/ Parents:.....
……
c/ Professional (Reformulation of the demand): ……. …….....
……
Specify: Untreated Treated ……..

CURRENT DISEASE

……
……
- Is anxious: No Yes …….....
(Specify is the conduct is extreme No Yes ……..)
- Is absent-minded/distracted: No Yes
…….....
- Is impulsive: No Yes …….....
- Is disobedient: No Yes …….....
- Is sad: No Yes …….....
- Cries often: No Yes …….....
- Makes negative comments:
- of themselves: No Yes …….....
- about life: No Yes ……..
(Specify any thoughts, threats or attempts of suicide:……)
- of their body: No Yes …….....
- Is afraid/has fears: No Yes ……..……..
(Specify if feared situations are avoided: ……)
- Excessive worrying: No Yes ……..……
(Specify any obsessions: ……..…….……)
- Problems with socialization: No Yes. …..……..……...

3

(Specify any difficulty with communication/interaction:……..……………………....)

- **Psychotic symptoms:** No Yes ………………………………………………………………
- **Bad eating habits:** No Yes ……………………………………………………………
- **Sleeps poorly:** No Yes ………………………………………………………………
- **Problematic behavior in the use of Video Games/Computers/TV:** No Yes

………………………………………………………………………No. hours/day………………….

- Gets irritable if unable to play,: Always Sometimes Never

(Specify other problematic risk behaviors ………….……………….………)

- **Teachers' opinion according to family history** ………………………………………..……

………………………………………………………………………………………………………

PERSONAL HISTORY

- **Pregnancy:** Normal Pathological: .... G.E.:....................weeks
- **Parto:** Normal Pathological: .... Wt. at birth.:.........................gm.
- **Neonatal Period:** Normal Pathological:...
- **PMD:**

Motor skills: Normal Pathological:..

Language: Normal Pathological:..

Literacy: Good Satisfactory .... Bad………...

Sphincter Control: Normal Pathological ○ Enuresis?:...

○ Encopresis?..

¿Has a specialist been consulted?: No Yes ....

- **Crossed laterality:** No Yes..

- Ambidextrous: No Yes - Left-handed: No Yes

- **Schooling:**

Current school year: .... Grade retention: No Yes ○ Current ○ Previous ○ Other ……………..

Anxiety when separated from parents at the start of schooling No Yes ....

School Changes No Yes ○ Normal ○ Extraordinary...

The schooling is Normal Integrated Special Other: ....

School performance Good Satisfactory Bad ....…………..…

Academic Problems No Yes ○ Behavioral ....

○ Achievement……...

- **Previous illnesses:** No Yes

- Physical: No Yes

....

- Mental: ○ Same RC ○ Other:..................................Untreated Treated…………………..

……

- **Hospitalizations:** No Yes ....
- **Operations**: No Yes ....
- **Previous neurological study?:** No Yes ....
- **Sight**: Normal Abnormal:..
- **Hearing**: Normal Abnormal:...
- **Menarche**: No Yes Age......... Irregular No Yes ....

4

FAMILY HISTORY.

- Parent marital status: Married Their relationship is: Good Average …… Bad ……
Separated Their relationship is: Good Average ……..… Bad……
Custody and visitation:.....
Child's reaction:……..……...
Single parent M F
Widow/er .....
(Specify if adopted No Yes Attitude toward being adopted Good Average Bad.....
Age of adoption:..... Other information.....)
- Changes in place of residence?: No Yes Number of times..... Country? No Yes .....
- Temporary separation from nuclear family No Yes……..
- Duration…… Caregiver during this period:…….
- Impact on child: None Little Some Large……..…
- Current family environment: Appropriate Inappropriate:.....
- What other people live at home? .....
- Family structure:
Siblings: No.:..... Twin? No Yes ..... Birth order:…….....
Names and ages:.....
Relationship with siblings: Good Average …….. Bad.....
Sibling/s have previously undergone psychiatric/psychological consultations: No Yes
.....
Father/Mother/Guardian: Name:..... Age..... Educational level.....
Work situation:.....Psychiatric consultations: No Yes.....
Father/Mother/Guardian: Name:..... Age..... Educational level.....
Work situation:.....Psychiatric consultations: No Yes.....
- **Existence of abuse**?: No Yes .....

- Deaths and cause of death:.....
Child's reaction: Appropriate Inappropriate .....

- Stressful or traumatic events: .....
Child's reaction: Appropriate Inappropriate
.....

CLINICAL EXAMINATION

1. The patient considers themselves to be:

One of the smartest Average One of the less clever Uncertain

……..
One of the happiest Average One of the less happy Uncertain

……..
One of the sportiest Average One of the less sporty Uncertain

……
2. Does he/she know the reason for the consultation? No Yes .....
3.- Likes/dislikes and hobbies:……..……..

(Specify if they are restricted or stereotyped: No Yes ……)

4. Peer social network:

a) Do he/she have friends? No Yes ……

b) Is he/she being mistreated by a classmate? No Yes ……

(Specify if the patient is being bullied……)

c) He/she gets on with everyone. No Yes ……

5. Family drawing.

Description:

5.1 Is everyone happy? No Yes, all of them equally

Happiest:.....

Less happy……

5.2 Is everyone good? No Yes, all of them equally

Most good……

Less good……

5.3 Who would have played a trick? ……

What trick?.....

What would have happened to them?.....

5.4. Would they all go on a trip together? Yes No someone would stay at home……

6. Cries: No Yes

……

7. Presents negative thoughts: No Yes

- about themselves……
- about life……
- about their body…… ……

8. What do they want to be when they grow up?.....

9. Their three top wishes:

……

.....Their **writing is assessed as:**

Good Average …… Bad……

10. Reversed number series: 3 digits 4 digits 5 digits 6 digits or more

Good Average …… Bad……

11. Reading and Reading Comprehension.

Good Average …… Bad……

12. EMA-DDA (parents)**:**

Impulsiveness	ADHD, Inattentive	ADHD, Hyperactivity

13. Psychiatrist's evaluation:

- **The patient is affected at the functional level:** No Yes

  Observations:……

- **- The patient is found to be worried:** No Yes

  Observations: ……

- **The patient is found to be nervous or unsettled:** No Yes

  Observations: ……

- **The patient is enthusiastic about getting better:** No Yes

  Observations: ……

14. Tests to be assessed for other possible diagnoses.

	Test administered	Score
Anxiety and stress	STAI	
Obsessive behaviors	LOI-CV	
Others		

15. Concluding remarks on the clinical examination:
……
……

REQUESTED TESTS

a) Psychological:.....
b) Medical: .....

DIAGNOSIS

Axis I:.....
Axis II:.....
Axis III:.....
Axis IV:.....
Axis V:.....

- Request for school report: No Yes
Other requested reports ……
- Referred or redirected to other services: No Yes……

TREATMENTS

○ Drugs (Course and Doses):.....
○ Psychotherapy (Type):.....
○ Social Services:.....
○ Family Attention Services.....
○ Child Attention Services.....
○ Adolescent Unit.....
○ Emergency Medical Form.....
○ Child Neurology.....
○ Other:.....

Discharge report: Yes Date:..... No

COORDINATION WITH SCHOOL

Results of the school report: ……

EMA-DDA (school):	Impulsiveness	ADHD, Inattentive	ADHD, Hyperactivity

Coordination meetings: .....

7

GENERAL REMARKS ABOUT THE CASE

.....
.....

ANNEX 2: School Report Form.

Annex 2: School Report Form.

SCHOOL REPORT - CHILD AND ADOLESCENT PSYCHIATRY

Name:.....
Surname(s):.....
School:..... Year:.....
Age:.....years

1. Do you consider him/her to be like the other children?
YES NO.....

2. Difficulties or aspects in which the child presents special problems (for example: psychomotor, sensory, sight and hearing, or language)
.....
.....
.....

3. Presents adequate learning in
Reading YES NO
Writing YES NO
Math YES NO

Comments: ……..
.....
.....

4. a) His/her level of attention is
High Normal Average Low
b) His/her level of interest for learning
High Normal Average Low
c) His/her level for acquiring and assimilating concepts is
High Normal Average Low

Comments:.....
.....
.....

5. Does the child participate in an integrated program at school?
NO YES.....
Due to:
A Issues in acculturation
B Delay in maturation or mental development
C Behind at school
D Other causes (specify…….....)
E Cause unknown

Comments:.....
.....

6. Is the local multidisciplinary psycho-pedagogical team familiar with child's situation?
NO YES ……..

7. Does the child attend support classes or rehabilitation?
NO
YES a) At the same school.
b) At another school (specify: ……..)

8. Do the parents show interest/participate in helping to resolve their child's potential difficulties at school?
A lot Some Little None

9. How does your student manifest himself/herself in class and at recess? How do they behave with their classmates and teachers?
.....
.....
.....

10. Remarks or additional information of any kind regarding the teachers' opinions about the child:
.....
.....
.....

11. If applicable:
School psychologist's report: ……...
.....
.....
Report provided by the local multidisciplinary psycho-pedagogical team
…….
.....
.....
.....
Other reports: …….
.....
.....
.....
Signed: (Teacher: Mr/Ms.....)

DATE:.....