Screening for Child and Adolescent Mental Health Issues
***(For Children Age 7+)**
For Dept. of Paediatric Oncology, KIDWAI Memorial Institute of Oncology
Developed by Community Child & Adolescent Mental Health Service Project
(Supported by DWCD)
Dept. of Child & Adolescent Psychiatry, NIMHANS

A. Basic Information

Name of Child: **Date:**
Age: **Sex:**

B. Emotional & Behavioural Issues

Issues		**Yes**	**No**
1.	You often feel worried or scared.		
2.	You often worry about how things will be after going back home.		
3.	You often worry how friends may feel about you/ what to say in case they ask about your health.		
4.	You often worry about how things will be when you go back to school.		
5.	You often worry about your treatment/pain/injection.		
6.	You feel worried/ upset when your parents feel worried/ upset (due to your health).		
7.	You often feel sad/like you want to cry.		
8.	You often like to be alone and don't feel like playing with other children.		
9.	You often feel angry and like you want to shout or hit others.		
10.	You often don't want to or refuse to take your medicines/ go for treatment.		
11.	You often feel that since you are sick, your parents and others must listen to you/give you everything you ask.		
12.	You have questions and worries about why you need to come to the hospital/ take medications/ treatment.		

C. Hospital Stay:

One thing you like about being here?

One thing you don't like about being here?

D. Illness & Pain

Has anyone at home/ in hospital told you anything about your hospital visits/stay and why you need to take medications/ to be on treatment? (Yes/ No)

Do you find the treatment/injections very painful? How painful it is? Look at the pain thermometer below and tell me, for most of the times how painful is your treatment?(Mark it).

0	1	2	3	4	5	6	7	8	9	10

Which procedure/treatment is most painful (If the child knows/ ask the child to describe)

*Referred for Depth Assessment/ Counselling (Yes/ No):