CLIENT SERVICE RECEIPT INVENTORY - CHILDREN'S VERSION – ICALM study – Baseline questionnaire

This instrument is to be completed with the young person. The retrospective period over which data sought is the last 3 months.

Participant ID: **Date:**

SCHOOL SUPPORT

1. Have you seen any of the following people in school/college in the last 3 months?

Professional	Number of contacts
Educational Psychologist	
Welfare Officer/Wellbeing Officer/Pastoral Support Worker/Safeguarding lead	
Classroom assistant	
Special education needs and disabilities (SEND) coordinator	
School nurse	
School Counsellor	
Other 1 Please say who ……	
Other 2 Please say who ……	

HEALTH SERVICE USE

2. Have you been prescribed any of the following medicines in the last 3 months? If so why and for how long?

Medicine	Y/N	If yes, reason for use	For how long?	Still taking this? (Y/N)
Fluoxetine				
Sertraline				
Melatonin/Circadin				
Promethazine				
Citalopram				
Propranolol				

3. Have you been prescribed any other medicines in the last 3 months? If so what, why and for how long?

Medicine	Reason for use	For how long?	Still taking this? (Y/N)

4. Please record any use of hospital in-patient services in the last 3 months.

Admission	**Reason for stay**	**Ward specialty (Type of ward)**	**No of inpatient days in last 3 months**
1			
2			
3			

5. Please record any use of other hospital services over the last 3 months.

Services used	**Number of attendances due to mental health problems**	**Number of other attendances**
A & E		
Paediatric out-patient		
Other out-patient		
Day Hospital Treatment setting		

6. Have you used any of the following services in the last 3 months? Please don't tell us about any person you saw at school or hospital who you told us about in previous questions.

Service	Number of contacts	Home visit? (tick for yes)
Health		
School nurse		
Mental Health Nurse		
Health visitor		
GP		
Paediatrician		
Physiotherapy		
Psychiatrist		
Clinical psychology		
Speech therapy out of school		
Hearing specialist		
Occupational Therapist (OT)		
Other		
Counselling		
Family therapist		
Individual therapy		
Other.....		
Support		
Home help/ care worker		
Day care centre		
Social worker		
Social services fostering		
After school club		
Other		

7. Have you stayed away overnight in any of the following places in the last 3 months?

Setting	How many days in total?
In a children's home	
With another foster carer	
Any other residential placement	

8. Has your family used any other services over the last 3 months as a result of your mental health? *(For example additional visits to the GP, family planning, social services, psychiatric services, marriage guidance, counselling, self help groups, alternative medicine, advice lines)*

Service	**Number of contacts**	**Home visit? (tick for yes)**

Thank-you for your help