version December 2017

Early Identification List
physical and psychological problems children

Name client:		**Date:**
Nationality:		Location:
Date of birth:		**Legal aid/lawyer:**
Gender:	Male / Female	Telephone number:
ID-number:		
Asylum procdedure:		

This questionnaire[1] is designed for refugee legal aid providers and asylum lawyers. It is a tool for the detection of mental illness. The first part of the questionnaire deals with observable conduct of the applicant. The second part covers questions that are asked to the person himself. Both parts of the questionnaire have their origin in the Istanbul Protocol (UN, 1999). The legal aid provider can send the questionnaire with an accompanying letter to the Home Office / the asylum authority.

OBSERVATIONS

Client has a tense body posture	yes/no
Client has motor disorders (e.g. tremor, jitteriness)	yes/no
Client react frightened by certain sounds	yes/no
Client cries a lot	yes/no
Client bursts into a bad temper	yes/no
Client has a very flat facial expression	yes/no
Client makes contact	yes/no
Client makes an absent impression	yes/no
Client jumps from one subject to another	yes/no
The story of the client is easy to understand	yes/no

QUESTIONNAIRE

Instruction: *"I'm going to name a number of complaints that people sometimes have. Can you tell if you suffered from any of these symptoms in the past week, including today?"*

Scars and physical complaints

11. Do you have scars or injuries related to your story?	yes/no
12. Do you have physical complaints caused by violence that you suffered, that relate to the reason of you asylum request?	yes/no

[1] The questionnaire was compiled from the questionnaires 'Observe behaviour- and health problems' and 'Indication of traumatization' by E. Bloemen (Pharos), R. Mellink (MAPP) and G. Oosterholt (RvR) and questions from the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist-25

Summary scars and physical complaints:

Psychological cpmplaints

13. Do you have little appetite (much less than usual)?	yes/no
14. Do you have trouble falling asleep or sleeping?	yes/no
15. Do you feel depressed almost every day?	yes/no
16. Do you sometimes consider making an end to your life?	yes/no
17. Do you feel having no interest at all in things?	yes/no
18. Do you have recurrent thoughts or memories of painful or frightening events?	yes/no
19. Do you have recurring nightmares?	yes/no
20. Do you avoid thoughts and feelings that remind you of painful or frightening events?	yes/no
21. Can you fully remember painful or frightening events?	yes/no
22. Do you have trouble concentrating?	yes/no
23. Do you often (almost daily) feel scared of frightened?	yes/no
24. Do you regularly suffer from a rapid or pounding heart?	yes/no
25. Do you suddenly startle or feel scared without a clear reason?	yes/no
26. Do you often suffer from headaches?	yes/no

Additional comment(s):