Parent/Guardian Instructions:

This questionnaire may take up to 30 minutes to complete and asks questions regarding gastrointestinal (GI) symptoms your child may have experienced. The questionnaire should only be completed by the child's primary caretaker (that is, the person who is responsible for taking care of the child most of the time). If you are not a primary caretaker, please let the staff member know who is so that we may contact that person.

This questionnaire is designed so you can fill it in yourself. There are no right or wrong answers, but please answer each question to the best of your ability. You may choose not to answer questions that make you uncomfortable.

While completing this survey it is okay to leave information blank or make additional notes regarding questions or comments you have. Once you have completed this form it will be reviewed with you by a staff member; at that time please ask any questions you had while trying to complete this form.

Please note that all information is kept strictly confidential.

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ATN ID: _ _ _ _ _ _ _ *Baseline Visit Only*

Section A: KEY IDENTIFYING INFORMATION

A1. Date form completed: ___ ___ / ___ ___ / ___ ___ ___ ___
M M D D Y Y Y Y

A2. Please indicate your relationship to the child enrolled in the ATN:

☐ BIOLOGICAL MOTHER ☐ BIOLOGICAL FATHER ☐ OTHER

If "Other", specify your relationship to the child: _____

Section B: GI Symptom Inventory Questionnaire

B1. For the following items (a-e) please answer the following:
i. In the last 3 months, has your child experienced any of the following gastrointestinal (tummy) symptoms?
ii. If "Yes", specify the duration of the symptoms (i.e. indicate how long the symptoms lasted).

		i. Experienced?			ii. If "Yes", specify duration:				
		NO	YES	UNSURE	< 3 MOS	3-5 MOS	6-11 MOS	1 YR OR LONGER	UNSURE
B1a.	Abdominal (belly) Pain:	☐	☐	☐	☐	☐	☐	☐	☐
B1b.	Nausea:	☐	☐	☐	☐	☐	☐	☐	☐
B1c.	Bloating:	☐	☐	☐	☐	☐	☐	☐	☐
B1d.	Not hungry after eating very little:	☐	☐	☐	☐	☐	☐	☐	☐
B1e.	Other symptom not listed:	☐	☐	☐	☐	☐	☐	☐	☐

If Other symptom, please specify: _____

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***INSTRUCTIONS**: If you answered "Yes" to your child experiencing any of the symptoms listed above, go to question B2, otherwise, skip to question B6.*

B2. In the last 3 months...	NO	YES	UNSURE
B2a. Did the symptom(s) get better after having a bowel movement?	☐	☐	☐
B2b. Were your child's bowel movements (BMs) softer or more watery than usual?	☐	☐	☐
B2c. Were your child's BMs harder or lumpier than usual?	☐	☐	☐
B2d. Did your child have more BMs than usual?	☐	☐	☐
B2e. Did your child have fewer BMs than usual?	☐	☐	☐
B2f. Did your child's symptom(s) occur before eating or when hungry?	☐	☐	☐
B2g. Did the symptom(s) change after your child ate?	☐	☐	☐
B2h. Did the symptom(s) wake your child from sleep?	☐	☐	☐

***INSTRUCTIONS**: If your child enrolled in the ATN is a girl, answer the next question, otherwise skip to question B4.*

B3. In the last 3 months, did your daughter's symptom(s) occur just before or during menstrual periods?

☐NO ☐YES ☐NO MENSTRUAL CYCLES ☐UNSURE

B4. In the last 3 months, did antacids relieve your child's symptom(s)?

☐NO ☐YES ☐NEVER USED ANTACIDS ☐UNSURE

B5. At what time of day did your child's symptom(s) usually begin?

☐DURING THE DAY, WHILE HE/SHE WAS AWAKE
☐AT NIGHT WHILE HE/SHE WAS ASLEEP
☐AT ANY TIME OF DAY OR NIGHT
☐UNSURE

B6. In the last year, did your child have severe gastrointestinal (tummy) pain that lasted 2 hours (or longer) and caused your child to stop all activities?

☐NO ☐YES ☐UNSURE

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B7. In the last 3 months, how often did your child usually have BMs?

- ☐ LESS THAN ONCE A WEEK
- ☐ 1-2 TIMES A WEEK
- ☐ 3-6 TIMES A WEEK
- ☐ ONCE A DAY
- ☐ 2-3 TIMES A DAY
- ☐ MORE THAN 3 TIMES A DAY
- ☐ UNSURE

B8. In the last 3 months, what were your child's BMs usually like?

- ☐ VERY HARD
- ☐ HARD
- ☐ NOT TOO HARD AND NOT TOO SOFT
- ☐ VERY SOFT OR MUSHY
- ☐ WATERY
- ☐ UNSURE

B9. In the last 3 months, did your child appear to feel pain when having a BM?

☐ NO ☐ YES ☐ UNSURE

B10. In the last 3 months, did your child have to rush to the bathroom for a BM?

☐ NO ☐ YES ☐ UNSURE

	NO	YES	UNSURE
B11. In the last 3 months, did your child pass mucus or phlegm during a BM? *(Mucus or phlegm: white/yellowish, stringy or slimy material)*	☐	☐	☐
B12. In the last 3 months, did you see your child stiffen his/her legs or squeeze his/her buttocks (bottom) and legs together when he/she felt the need to have a BM?	☐	☐	☐
B13. After passing a stool, was your child...			
B13a. More active?	☐	☐	☐
B13b. Less irritable?	☐	☐	☐
B14. In the last 3 months, did your child stain or soil underwear?	☐	☐	☐
B15. Has your child ever had a black, tarry BM?	☐	☐	☐
B16. Has your child ever had red blood in or after a BM?	☐	☐	☐
B17. In the last 3 months, has your child...			
B17a. Spit up 2 or more times a day?	☐	☐	☐
B17b. Experienced retching? *(Retching- dry heaves, try to vomit but nothing comes up)*	☐	☐	☐
B17c. Tilted head to the side and arched back?	☐	☐	☐
B17d. Regurgitated food and chewed it again? *(Regurgitation- food comes back up but there is no nausea or attempt to vomit.)*	☐	☐	☐

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	NO	YES	UNSURE
B18. In the last 3 months, has your child had trouble gaining weight?	☐	☐	☐
B19. In the last 3 months, did your child miss activities because of...			
B19a. Pain and/or discomfort?	☐	☐	☐
B19b. Vomiting?	☐	☐	☐
B19c. Problems with BMs?	☐	☐	☐
B19d. Excessive gas?	☐	☐	☐

B20. Some parents may have difficulty describing/assessing their child's pain. Do you feel confident that you can accurately assess your child's pain?

EXTREMELY UNSURE	VERY UNSURE	SOMEWHAT SURE	VERY SURE	EXTREMELY SURE
☐	☐	☐	☐	☐

	NO	YES	UNSURE
B21. In the last 3 months did your child push his abdomen with his/her hands or your hands, push his/her abdomen against or lean forward over furniture?	☐	☐	☐
B22. In the last 3 months, did your child do things like punching her/his chest or neck, putting her/his fist into their mouth, or biting her/his hands or wrist without a reason?	☐	☐	☐
B23. In the last 3 months, did your child choke, gag, cough, or sound wet during or after swallowing or with meals?	☐	☐	☐
B24. In the last 3 months, has your child started to refuse many foods that he or she would eat in the past?	☐	☐	☐

Thank you for taking the time to complete this survey! (END OF FORM)

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ATN ID: _ _ _ _ _ _ _ _

Staff Reviewer:_____ Date of Review:___/___/___