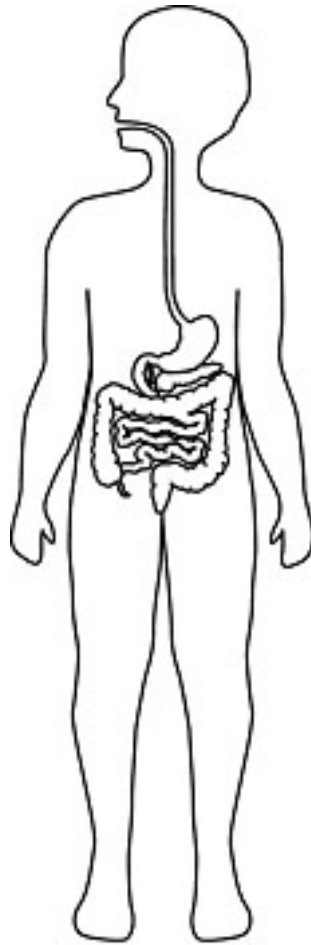


## **Questionnaire on Gastrointestinal Symptoms in Children**

(Walker, Caplan-Dover, & Rasquin-Weber, 2000)

### **Research Form A: Parents of Children and Adolescents (4-17 years old)**



### **Instructions**

This questionnaire concerns the usual functioning of your child's digestive system and the gastrointestinal symptoms or problems that your child can have. Some of these symptoms apply to your child and others do not. In certain cases, you may not know about your child's more private problems and you will be able to indicate that you do not know.

Please try to answer all of the questions as best as you can.

If you need an explanation, the research assistant will be glad to help!

1. Today's date: month:\_\_\_\_\_ day:\_\_\_\_\_ year:\_\_\_\_\_
2. Child's name: \_\_\_\_\_
3. Your relationship to child: \_\_\_\_\_mother \_\_\_\_\_father \_\_\_\_\_other (Please specify: \_\_\_\_\_)
4. Is your child a boy or a girl?
  1. \_\_\_\_ boy
  2. \_\_\_\_ girl
5. Child's date of birth: month:\_\_\_\_\_ day:\_\_\_\_\_ year:\_\_\_\_\_
6. To which ethnic group does your child belong?
  1. \_\_\_\_ African-American
  2. \_\_\_\_ Asian/Pacific Islander
  3. \_\_\_\_ Hispanic/Latino
  4. \_\_\_\_ Native American
  5. \_\_\_\_ White (Caucasian)
  6. \_\_\_\_ Other (Please specify: \_\_\_\_\_)
7. Does your child have any chronic (recurring) health problems (such as seizures, asthma, diabetes)?
  0. \_\_\_\_ No
  1. \_\_\_\_ Yes. Please describe your child's health problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Does your child take any prescription or nonprescription medications or treatments?
  0. \_\_\_\_ No
  1. \_\_\_\_ Yes. Please list current medications or treatments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. Has your child ever had surgery?
  0. \_\_\_\_ No
  1. \_\_\_\_ Yes. Please specify type of surgery and child's age at the time of surgery: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Does your child have any allergies? For example, does your child have hay fever or allergic reactions to milk, other foods, or medications?
  0. \_\_\_\_ No
  1. \_\_\_\_ Yes. Please specify type of allergy: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Does your child have any developmental problems? For example, does your child have a learning disability or developmental delay?

0. ☐ No

1. ☐ Yes. Please specify: \_\_\_\_\_

12. Some children are taught at home because they are too sick to go to school. Is your child taught at home because of illness?

0. ☐ No

1. ☐ Yes

13. Please indicate if anyone in your child's biological family has a gastrointestinal disorder (such as ulcer, Crohn's Disease, pancreatitis, irritable bowel syndrome).

0. ☐ No 1. ☐ Yes Your child's mother (Condition: \_\_\_\_\_)

0. ☐ No 1. ☐ Yes Your child's father (Condition: \_\_\_\_\_)

0. ☐ No 1. ☐ Yes Your child's sister (Condition: \_\_\_\_\_)

0. ☐ No 1. ☐ Yes Your child's brother (Condition: \_\_\_\_\_)

0. ☐ No 1. ☐ Yes Other (who?: \_\_\_\_\_ Condition: \_\_\_\_\_)

14. Please indicate if anyone in your child's biological family has migraine headaches.

0. ☐ No 1. ☐ Yes Your child's mother

0. ☐ No 1. ☐ Yes Your child's father

0. ☐ No 1. ☐ Yes Your child's sister

0. ☐ No 1. ☐ Yes Your child's brother

0. ☐ No 1. ☐ Yes Other (Specify who: \_\_\_\_\_)

15. Do you have any concerns about your child's eating habits, bowel movements, toilet training, vomiting, abdominal pain, or other health problems? Please describe your concerns below:

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## Section A. Pain and Discomfort in the Upper Abdomen (Above the Navel).

This section is about abdominal pain, stomach aches, and other abdominal discomfort in the upper abdomen, **above the navel**, that your child may have had *in the last 3 months* (see figure below). These symptoms may include pain or uncomfortable sensations such as nausea, bloating, a feeling of fullness, or not being hungry after eating very little. (Your child may have had pain or discomfort in more than one area of the abdomen. Section B of the questionnaire will ask about pain or discomfort around and/or below the navel.)



Above the Navel

1. In the last 3 months, how often did your child have pain or discomfort (nausea, bloating, feeling of fullness, and/or not being hungry after eating very little) *in the upper abdomen above the navel*?
  0. ☐ Never
  1. ☐ Less than once a month
  2. ☐ One to three times a month
  3. ☐ Once a week
  4. ☐ Several times a week
  5. ☐ Every day

*If your child has not had ANY pain or discomfort in the upper abdomen in the past 3 months, please go to Section B.*

2. Which of the following symptoms did your child have *in the upper abdomen above the navel*? (You may check one or more symptoms.)
 

a. Pain	0. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes
b. Nausea	0. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes
c. Bloating	0. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes
d. Feeling of fullness	0. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes
e. Not being hungry after eating very little	0. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes
3. In the last 3 months, which bothered your child the **most**?
  1. ☐ Pain in the upper abdomen
  2. ☐ A feeling in the upper abdomen that was uncomfortable but not painful (for example, nausea, bloating, a feeling of fullness, or not being hungry after eating very little).
  3. ☐ Both.
  7. ☐ I don't know which bothered my child the most.

4. In the last 3 months, what was the usual intensity of your child's pain or discomfort *in the upper abdomen above the navel*?
1. \_\_\_\_\_ Mild
  2. \_\_\_\_\_ Moderate
  3. \_\_\_\_\_ Severe
  4. \_\_\_\_\_ Very Severe
5. For how long has your child had pain or discomfort *in the upper abdomen above the navel*?
1. \_\_\_\_\_ One month or less
  2. \_\_\_\_\_ Two months
  3. \_\_\_\_\_ Three months
  4. \_\_\_\_\_ Four to Eleven months
  5. \_\_\_\_\_ One year or longer
6. In the last 3 months, when your child had pain or discomfort *in the upper abdomen above the navel*, how long did it usually last?
1. \_\_\_\_\_ Less than an hour
  2. \_\_\_\_\_ One to Two hours
  3. \_\_\_\_\_ Three to Four hours
  4. \_\_\_\_\_ Most of the day
  5. \_\_\_\_\_ One or more days
7. In the last 3 months, how often did antacids relieve your child's pain or discomfort *in the upper abdomen above the navel*?
8. \_\_\_\_\_ Does not apply; child did not take antacids
  0. \_\_\_\_\_ Never
  1. \_\_\_\_\_ Once in a while
  2. \_\_\_\_\_ Sometimes
  3. \_\_\_\_\_ Most of the time
  4. \_\_\_\_\_ Always

Circle a number to indicate your response to each question.

<b>In the last 3 months, when your child had pain or discomfort in the upper abdomen above the navel, how often:</b>		<u>Never</u>	<u>Once in a while</u>	<u>Some-times</u>	<u>Most of the time</u>	<u>Always</u>	<u>I don't know</u>
8.	Did it get better after having a bowel movement?	0	1	2	3	4	_____
9.	Were your child's bowel movements softer and more mushy or watery than usual?	0	1	2	3	4	_____
10.	Were your child's bowel movements harder or lumpier than usual?	0	1	2	3	4	_____
11.	Did your child have more bowel movements than usual?	0	1	2	3	4	_____
12.	Did your child have fewer bowel movements than usual?	0	1	2	3	4	_____

## Section B. Belly Aches and Abdominal Pain Around and/or Below the Navel

This section is about belly aches and abdominal pain around and/or below the navel that your child may have had *in the last 3 months* (see figure below). Belly aches are sometimes milder and more vague than abdominal pain. Some children refer to their belly aches or abdominal pain as “stomach aches,” or “tummy aches.”



**Around the Navel**



**Below the Navel**

1. In the last 3 months, how often did your child have a belly ache or abdominal pain *in the area around or below the navel*?
  0. ☐ Never
  1. ☐ Less than once a month
  2. ☐ One to Three times a month
  3. ☐ Once a week
  4. ☐ Several times a week
  5. ☐ Every day

*If your child has NOT had ANY belly aches or abdominal pain around or below the navel in the past 3 months, please go to Section C.*

2. In the last 3 months, what was the usual intensity of your child's belly aches or abdominal pain *in the area around or below the navel*?
  1. ☐ Mild
  2. ☐ Moderate
  3. ☐ Severe
  4. ☐ Very severe
3. For how long has your child had belly aches or abdominal pain *in the area around or below the navel*?
  1. ☐ One month or less
  2. ☐ Two months
  3. ☐ Three months
  4. ☐ Four to Eleven months
  5. ☐ One year ago or longer
4. In the last 3 months, when your child had belly aches or abdominal pain *around or below the navel*, how long did it usually last?
  1. ☐ Less than an hour
  2. ☐ One to Two hours
  3. ☐ Three to Four hours
  4. ☐ Most of the day
  5. ☐ One or more days

*Circle a number to indicate your response to each question.*

**In the last 3 months, when your child had a belly ache/pain around or below the navel, how often:**

	<u>Never</u>	<u>Once in a while</u>	<u>Some-times</u>	<u>Most of the time</u>	<u>Always</u>	<u>I don't know</u>
5. Did it get better after having a bowel movement?	0	1	2	3	4	_____
6. Were your child's bowel movements softer and more mushy or watery than usual?	0	1	2	3	4	_____
7. Were your child's bowel movements harder or lumpier than usual?	0	1	2	3	4	_____
8. Did your child have more bowel movements than usual?	0	1	2	3	4	_____
9. Did your child have fewer bowel movements than usual?	0	1	2	3	4	_____
10. Did your child's belly ache or pain occur before eating or when hungry?	0	1	2	3	4	_____
11. Did the belly ache or pain get worse soon after your child ate?	0	1	2	3	4	_____
12. Did the belly ache or pain get better after your child ate?	0	1	2	3	4	_____
13. Were your child's eyes sensitive to light?	0	1	2	3	4	_____
14. Did your child have a headache?	0	1	2	3	4	_____
15. Did your child have a headache on one side of the head?	0	1	2	3	4	_____
16. Did your child vomit?	0	1	2	3	4	_____
17. Was your child's skin pale?	0	1	2	3	4	_____
18. Did your child sweat more than usual?	0	1	2	3	4	_____
19. Did your child have nausea (appeared weak and pale or felt like he/she might vomit)?	0	1	2	3	4	_____
20. Did your child have a feeling of fullness?	0	1	2	3	4	_____
21. Did your child stop being hungry after eating very little?	0	1	2	3	4	_____
22. Did your child's abdomen become bloated?	0	1	2	3	4	_____

23. Parents of girls only: In the last 3 months, did your daughter's belly aches or abdominal pain *around or below the navel* usually occur just before or during her menstrual period?
0. \_\_\_\_ No                                  2. \_\_\_\_ Check here if your daughter did not have  
1. \_\_\_\_ Yes\*                                menstrual periods.

\*23a. If yes, was the belly ache or abdominal pain different from menstrual pain?

0. \_\_\_\_\_ No  
1. \_\_\_\_\_ Yes

24. In the last 3 months, how often did antacids relieve your child's belly ache or abdominal pain *around or below the navel*?

8. \_\_\_\_ Does not apply; child did not take antacids  
0. \_\_\_\_ Never  
1. \_\_\_\_ Once in a while  
2. \_\_\_\_ Sometimes  
3. \_\_\_\_ Most of the time  
4. \_\_\_\_ Always

25. At what time of day did your child's belly ache or abdominal pain *around or below the navel* usually begin?

1. \_\_\_\_\_ During the day, while he/she was awake
2. \_\_\_\_\_ At night, while he/she was asleep
3. \_\_\_\_\_ At any time of day or night

26. Did your child have any of the following symptoms **within the hour** before his or her belly ache or abdominal pain began?

- |                               |           |            |                     |
|-------------------------------|-----------|------------|---------------------|
| a. Blurred vision             | 0. ___ No | 1. ___ Yes | 7. ___ I don't know |
| b. Numbness or tingling       | 0. ___ No | 1. ___ Yes | 7. ___ I don't know |
| c. Difficulty speaking        | 0. ___ No | 1. ___ Yes | 7. ___ I don't know |
| d. Paralysis (unable to move) | 0. ___ No | 1. ___ Yes | 7. ___ I don't know |

27. In the last **year**, how many times did your child have **severe pain** around the navel that **lasted two hours or longer** and caused your child to **stop all activities**?

0. \_\_\_\_\_ Never  
1. \_\_\_\_\_ One to Two times  
2. \_\_\_\_\_ Three to Five times  
3. \_\_\_\_\_ Six to Nine times  
4. \_\_\_\_\_ Ten or more times

- 27a. Was your child in good health for several weeks or longer between the episodes of severe pain?

- 0.\_\_\_\_ No  
pain  
1.\_\_\_\_ Yes
- 8.\_\_\_\_ Does not apply; child did not have episodes of severe



## Section C. Bowel Movements (“Poop,” “Stool,” “Number 2”)

This section asks about your child’s bowel movements. There are many words for bowel movements. Some of these are “poop,” “stool,” “BM’s,” and “going to the bathroom for number 2.” Your family may have another special word to refer to bowel movements.

1. Has your child been **completely** toilet trained for at least 3 months?  
☐ No. If no, are you currently trying to toilet-train your child? 0. ☐ No 1. ☐ Yes  
 2. ☐ Yes
2. How much do you know about your child’s bowel habits? (For example, do you know the frequency and consistency of your child’s bowel movements?)  
 2. ☐ I know a lot about my child’s bowel habits.  
 1. ☐ I know some about my child’s bowel habits.  
 0. ☐ I know nothing or very little about my child’s bowel habits.
3. In the last 3 months, how often did your child usually have bowel movements?  
 1. ☐ Less than once a week  
 2. ☐ One to Two times a week  
 3. ☐ Three to Six times a week 7. ☐ I don’t know  
 4. ☐ Once a day  
 5. ☐ Two to Three times a day  
 6. ☐ More than Three times a day
4. In the last 3 months, what were your child’s bowel movements usually like?  
 1. ☐ Very hard  
 2. ☐ Hard 6. ☐ Sometimes hard; sometimes soft  
 3. ☐ Not too hard and not too soft 7. ☐ I don’t know  
 4. ☐ Very soft or mushy  
 5. ☐ Watery
5. In the last 3 months, for how long did your child usually have fewer than 3 bowel movements a week?  
 0. ☐ Never  
 1. ☐ One week  
 2. ☐ Two weeks 7. ☐ I don’t know  
 3. ☐ Three weeks  
 4. ☐ One month  
 5. ☐ Two months  
 6. ☐ Three or more months
6. In the last 3 months, for how long were most of your child’s stools (poops) hard or like pebbles?  
 0. ☐ Never  
 1. ☐ One week  
 2. ☐ Two weeks 7. ☐ I don’t know  
 3. ☐ Three weeks  
 4. ☐ One month  
 5. ☐ Two months  
 6. ☐ Three or more months

7. In the last 3 months, for how long did your child have very soft, mushy, or watery bowel movements (diarrhea) 3 or more times a day?

0.\_\_\_\_ Never

1.\_\_\_\_ One week

2.\_\_\_\_ Two weeks

3.\_\_\_\_ Three weeks

4.\_\_\_\_ One month

5.\_\_\_\_ Two months

6.\_\_\_\_ Three or more months

7.\_\_\_\_ I don't know

\_\_\_\_ Check here if child is taking laxatives (8)

8. In the last 3 months, did your child appear to feel pain when having a soft bowel movement?

0.\_\_\_\_ No

1.\_\_\_\_ Yes

8.\_\_\_\_ Does not apply; child did not have soft bowel movements

*Circle a number to indicate your response to each question.*

	<u>Never</u>	<u>Once in a while</u>	<u>Some- times</u>	<u>Most of the time</u>	<u>Always</u>	<u>I don't know</u>
<b>In the last 3 months, how often:</b>						
9. Did your child have to rush to the bathroom for a bowel movement?	0	1	2	3	4	_____
10. Did your child have to strain (push hard) to have a bowel movement?	0	1	2	3	4	_____
11. Did your child pass mucus or phlegm (white, yellowish, stringy, or slimy material) during a bowel movement?	0	1	2	3	4	_____
12. Did your child have a feeling of not being finished after a bowel movement (like there was more that wouldn't come out)?	0	1	2	3	4	_____

13. In the last 3 months, how often did your child pass stools (poops) that were much thicker (wider in diameter) than you think is normal?

0.\_\_\_\_ Never

1.\_\_\_\_ Less than once a month

2.\_\_\_\_ One to Three times a month

3.\_\_\_\_ Once a week

4.\_\_\_\_ Several times a week

5.\_\_\_\_ Every day

7.\_\_\_\_ I don't know

14. In the last 3 months, how often did it appear that your child was trying to hold in a bowel movement?

0.\_\_\_\_ Never

1.\_\_\_\_ Less than once a month

2.\_\_\_\_ One to Three times a month

3.\_\_\_\_ Once a week

4.\_\_\_\_ Several times a week

5.\_\_\_\_ Every day

7.\_\_\_\_ I don't know

15. In the last 3 months, how often was your child afraid to have a bowel movement because he/she thought it would hurt when it came out?
0. ☐ Never  
 1. ☐ Less than once a month  
 2. ☐ One to Three times a month  
 3. ☐ Once a week  
 4. ☐ Several times a week  
 5. ☐ Every day  
 7. ☐ I don't know
16. In the last 3 months, when your child **felt the need** to have a bowel movement (before going to the bathroom), how often did you see your child **stiffen his/her legs or squeeze his/her buttocks (bottom) and legs together**?
0. ☐ Never. *If never, please go to question #17.*  
 1. ☐ Less than once a month  
 2. ☐ One to Three times a month  
 3. ☐ Once a week  
 4. ☐ Several times a week  
 5. ☐ Every day
- 16a. For how long has your child adopted this position when he/she felt the need to have a bowel movement?
1. ☐ One month or less  
 2. ☐ Two months  
 3. ☐ Three months  
 4. ☐ Four to Eleven months  
 5. ☐ One year ago or longer
- 16b. When your child is in this position, does your child:
- |                                   |                                |                                 |
|-----------------------------------|--------------------------------|---------------------------------|
| a. Grunt and get red in the face? | 0. <input type="checkbox"/> No | 1. <input type="checkbox"/> Yes |
| b. Hide?                          | 0. <input type="checkbox"/> No | 1. <input type="checkbox"/> Yes |
| c. Appear to be in pain?          | 0. <input type="checkbox"/> No | 1. <input type="checkbox"/> Yes |
| d. Become irritable?              | 0. <input type="checkbox"/> No | 1. <input type="checkbox"/> Yes |
| e. Have a poor appetite?          | 0. <input type="checkbox"/> No | 1. <input type="checkbox"/> Yes |
17. After finally passing a very thick stool (poop), was your child . . .
- |                       |                                |                                 |  |
|-----------------------|--------------------------------|---------------------------------|--|
| a. more active?       | 0. <input type="checkbox"/> No | 1. <input type="checkbox"/> Yes | 8. <input type="checkbox"/> Does not apply |
| b. in a happier mood? | 0. <input type="checkbox"/> No | 1. <input type="checkbox"/> Yes | 8. <input type="checkbox"/> Does not apply |
18. In the last 3 months, did your child have a bowel movement while sleeping?
0. ☐ No  
 1. ☐ Yes
19. In the last 3 months, how often was your child's underwear stained or soiled with stool (poop)?
0. ☐ Never. *If never, please go to Section D.*  
 1. ☐ Less than once a month  
 2. ☐ One to Three times a month  
 3. ☐ Once a week  
 4. ☐ Several times a week  
 5. ☐ Every day

19a. When your child soiled, how much did your child usually soil?

1. \_\_\_\_\_ Underwear was stained (no stool)
2. \_\_\_\_\_ Small amount of stool in underwear (less than a complete bowel movement)
3. \_\_\_\_\_ Large amount of stool in underwear (complete bowel movement)

19b. After your child passed a very large stool (poop), did the soiling stop for a day or more?

0. \_\_\_\_\_ No
1. \_\_\_\_\_ Yes                      8. \_\_\_\_\_ Does not apply. Child did not pass large stools (poops).

19c. For how long has your child soiled his/her underwear?

1. \_\_\_\_\_ One month or less
2. \_\_\_\_\_ Two months
3. \_\_\_\_\_ Three months
4. \_\_\_\_\_ Four to Eleven months
5. \_\_\_\_\_ One year or longer

## Section D. Other symptoms

This section is about other digestive symptoms. Please indicate how often your child has had each symptom in the last 3 months.

<i>Circle a number to indicate your response to each question.</i>		<u>Never</u>	<u>1-3 times a month</u>	<u>Once a week</u>	<u>Several times a week</u>	<u>Every day</u>	<u>I don't know</u>
<b>In the last 3 months, how often did your child:</b>							
1.	Get the feeling of having a lump in his or her throat?	0	1	2	3	4	_____
2.	Have difficulty swallowing (food or liquids got stuck or went down abnormally)?	0	1	2	3	4	_____
3.	Have heartburn (burning pain or discomfort in the throat or chest)?	0	1	2	3	4	_____
4.	Have acid-tasting fluid at the back of his or her throat?	0	1	2	3	4	_____
5.	Regurgitate food into his or her throat? (Regurgitation is when food comes up but there is no nausea and the stomach muscles do not make strong contractions.)	0	1	2	3	4	_____
6.	Burp (belch) <i>again and again</i> without wanting to?	0	1	2	3	4	_____
7.	Pass gas <i>very frequently</i> ?	0	1	2	3	4	_____
8.	Have a <i>visibly</i> swollen or bloated abdomen?	0	1	2	3	4	_____

9. If your child's abdomen was *visibly* swollen or bloated in the last 3 months, what time of day was it most swollen?
- 1.\_\_\_\_ In the morning      8.\_\_\_\_ Does not apply; child's abdomen was not swollen.  
2.\_\_\_\_ In the evening  
3.\_\_\_\_ All times of day and night
10. In the last 3 months, how often did it appear that your child was swallowing air? (This may be associated with a clicking noise when swallowing)
- 0.\_\_\_\_ Never  
1.\_\_\_\_ Less than once a month  
2.\_\_\_\_ One to Three times a month  
3.\_\_\_\_ Once a week  
4.\_\_\_\_ Several times a week  
5.\_\_\_\_ Every day
11. *In the past year*, how many times did your child **vomit again and again without stopping for two hours or longer?**
- 0.\_\_\_\_ Never. *If never, please go to Section E.*  
1.\_\_\_\_ Once  
2.\_\_\_\_ Twice  
3.\_\_\_\_ Three times  
4.\_\_\_\_ Four or more times
- 11a. For how long has your child been vomiting again and again without stopping for two hours or longer?
- 1.\_\_\_\_ One month or less  
2.\_\_\_\_ Two months  
3.\_\_\_\_ Three months  
4.\_\_\_\_ Four to Eleven months  
5.\_\_\_\_ One year ago or longer
- 11b. Did your child usually feel nausea when he or she vomited again and again without stopping for two hours or longer?
- 0.\_\_\_\_ No  
1.\_\_\_\_ Yes
- 11c. Was your child in good health for several weeks or longer between the times when he or she vomited again and again?
- 0.\_\_\_\_ No  
1.\_\_\_\_ Yes

**Section E. Limitations in activities because of symptoms**

*Circle a number to indicate your response to each question.*

<b>In the last 3 months, how often did your child miss activities at school (including class work, sports, and other activities):</b>	<u>Never</u>	<u>1-3 times a month</u>	<u>Once a week</u>	<u>Several times a week</u>	<u>Every day</u>	<u>I don't know</u>
1. Because of pain or discomfort ABOVE the navel?	0	1	2	3	4	___
2. Because of belly aches or pain AROUND or BELOW the navel?	0	1	2	3	4	___
3. Because of problems with bowel movements?	0	1	2	3	4	___
4. Because of vomiting?	0	1	2	3	4	___
5. Because of problems with passing gas or belching?	0	1	2	3	4	___
6. Because of other symptoms? (Specify: _____)	0	1	2	3	4	___

*Circle a number to indicate your response to each question.*

<b>In the last 3 months, how often did your child miss activities with friends or at home:</b>	<u>Never</u>	<u>1-3 times a month</u>	<u>Once a week</u>	<u>Several times a week</u>	<u>Every day</u>	<u>I don't know</u>
7. Because of pain or discomfort ABOVE the navel?	0	1	2	3	4	___
8. Because of belly aches or pain AROUND or BELOW the navel?	0	1	2	3	4	___
9. Because of problems with bowel movements?	0	1	2	3	4	___
10. Because of vomiting?	0	1	2	3	4	___
11. Because of passing gas or belching?	0	1	2	3	4	___
12. Because of other symptoms? (Specify: _____)	0	1	2	3	4	___

Circle a number to indicate your response to each question.

<b>In the last 3 months, how often:</b>	<u>Never</u>	1-3 times a <u>month</u>	Once a <u>week</u>	Several times a <u>week</u>	Every <u>day</u>	I don't <u>know</u>
13. Did <i>you or other family members</i> miss work in order to bring your child to the doctor or to stay home when your child had any of the gastrointestinal problems described above?	0	1	2	3	4	___
14. Were family activities limited because of your child's gastrointestinal problems described above?	0	1	2	3	4	___

The questionnaire ends here. Thank you very much for your help!