Center for Autism and Developmental Disabilities Research and Epidemiology
CADDRE

Form Approved
OMB NO. 0920-0741
Exp. Date: 6/30/2010

Study to Explore Early Development

Survey of Gastrointestinal Function

Study ID # _____
Date of Completion: _____

Please answer the following questions about your child's eating habits and stool patterns.

1. Do you feel like your child's diet is…
   - ☐ Good
   - ☐ Limited
   - ☐ Poor
   - ☐ Don't know

2. Does your child <u>currently</u> have any diet restrictions?
   - ☐ Yes
   - ☐ No (*go to question 6*)
   - ☐ Don't know (*go to question 6*)

3. If yes, what are the diet restrictions? Please list all.

_____

_____

_____

4. Is your child's diet… *Check all that apply*
   - ☐ Self- restricted
   - ☐ Parent- restricted
   - ☐ Medically prescribed
   - ☐ Don't know

5. Why does your child have diet restrictions? Please describe symptoms that are affected by food, such as stool consistency, stool frequency, rash, or behavior.

_____

_____

_____

6. Has your child <u>ever</u> had difficulty swallowing on a regular basis (for 2-3 weeks)?
   - ☐ Yes
   - ☐ No (*go to question 11*)
   - ☐ Don't know (*go to question 11*)

7. At what age did your child have this problem? Please record your child's age for each instance he or she had this problem.

   1st instance: _____ months or _____ years

   2nd instance: _____ months or _____ years

   3rd instance: _____ months or _____ years

8. What types of food did your child have difficulty swallowing?

	Yes	No	Don't know
a. Liquid……..	□	□	□
b. Solid…….	□	□	□
c. Nectar……	□	□	□

9. Has your child ever had a swallow study?

   □ Yes
   □ No (*go to question 11*)
   □ Don't know (*go to question 11*)

10. Was the result of the study normal or abnormal for

	Normal	Abnormal	Don't know
a. Thin liquids……..□		□	□
b. Solids…….□		□	□
c. Nectar……..□		□	□

11. Has your child <u>ever</u> rejected certain textures of foods for more than 2 - 3 weeks?

   □ Yes
   □ No (*go to question 14*)
   □ Don't know (*go to question 14*)

12. At what age did your child reject textures? Please record your child's age for each instance he or she rejected textures.

   1st instance: _____ months or _____ years

   2nd instance: _____ months or _____ years

   3rd instance: _____ months or _____ years

13. What textures of food did your child reject?

	Yes	No	Don't know
a. Hard to chew …….. (tough meat or raw carrot)	☐	☐	☐
b. Crunchy……..	☐	☐	☐
c. Mushy……..	☐	☐	☐
d. Sticky …….....	☐	☐	☐
e. Lumps …….....	☐	☐	☐
f. Mixed texture ……..... (mixture of at least two of the above textures)	☐	☐	☐
g. Other …….. Specify: _____	☐	☐	☐

14. Do you feel that your child <u>currently</u> has gastrointestinal (bowel) problems on a regular basis (more than 2 times a month)?

☐ Yes
☐ No (*go to question 18*)
☐ Don't know (*go to question 18*)

15. Does your child have any of the following gastrointestinal problems?

	Yes	No	Don't know
a. Vomiting ……	☐	☐	☐
b. Diarrhea ……	☐	☐	☐
c. Loose stools ……	☐	☐	☐
d. Constipation ……	☐	☐	☐
e. Loose stools alternating with constipation …	☐	☐	☐
f. Abdominal pain with meals …….	☐	☐	☐
g. Abdominal pain relieved by defecation ….	☐	☐	☐
h. Pain on stooling ……	☐	☐	☐
i. Gas……	☐	☐	☐
j. Other …… Specify _____	☐	☐	☐

If yes for <u>any</u> condition in question 15, please complete questions 16 and 17.
If no or don't know for <u>all</u> the above conditions, go to question 18.

16. How old was your child when the problem started? Please respond for each condition you checked "Yes" in question 15.

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Condition	Age Problem Started
Example: __<u>diarrhea</u>__	*___<u>32</u>__ months or _____ years*
1. _____	_____ months or _____ years
2. _____	_____ months or _____ years
3. _____	_____ months or _____ years
4. _____	_____ months or _____ years
5. _____	_____ months or _____ years

17. How often does your child have the problem? Please respond for each condition you checked "Yes" in question 15.

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Condition	2-4 times per month	1-2 times per week	3-6 times per week	Daily	Don't know
1. _____	☐	☐	☐	☐	☐
2. _____	☐	☐	☐	☐	☐
3. _____	☐	☐	☐	☐	☐
4. _____	☐	☐	☐	☐	☐
5. _____	☐	☐	☐	☐	☐

18. Do you feel that your child had gastrointestinal symptoms <u>in the past</u> that are <u>not</u> present now?

☐ Yes
☐ No (*go to question 21*)
☐ Don't know (*go to question 21*)

19. At what age did the symptoms go away?

_____ months or _____ years

20. What did you do that made the symptoms go away? Please be specific.

_____

_____

_____

21. In the <u>past 30 days</u>, has your child used stool softeners, laxatives or fiber supplements?

☐ Yes
☐ No (*go to question 24*)
☐ Don't know (*go to question 24*)

22. What was the name of the product(s)?

_____

_____

23. How many times during the month did your child use the product(s)?

Product 1 _____

Product 2 _____

Product 3 _____

24. Does your child vomit more than once a month when not associated with an illness?

□ Yes
□ No (*go to question 26*)
□ Don't know (*go to question 26*)

25. What seems to cause the vomiting? *Check all that apply.*

□ Crying
□ Stress
□ Certain smells
□ Eating too quickly
□ Eating too much
□ Reflux
□ Other: _____
□ Don't know

26. Is there <u>ever</u> any blood in your child's stool?

□ Yes
□ No
□ Don't know

27. Has there <u>ever</u> been a time when your child's stools were greasy, mucousy, frothy, or more foul smelling than usual, more than once a week for a long period of time?

	Yes	No	Don't know
a. Greasy ……..	□	□	□
b. Mucousy ……	□	□	□
c. Frothy ……..	□	□	□
d. More foul smelling …….	□	□	□

If yes for <u>any</u> condition in 27, please answer question 28.
If no or don't know for <u>all</u> conditions, please go to question 29.

28. At what age(s)? Please respond for each condition you checked "Yes" in question 27.

Condition	Age Problem Started
Example: __<u>greasy</u>__	___<u>32</u>__ months or _____ *years*
1. _____	_____ months or _____ years
2. _____	_____ months or _____ years
3. _____	_____ months or _____ years
4. _____	_____ months or _____ years

29. Has your child <u>ever</u> had a severe episode of dehydration requiring medical care?

□ Yes
□ No (*go to question 32*)
□ Don't know (*go to question 32*)

30. How many times has your child had such a dehydration episode?

_____ times

31. What type of medical care did your child receive for dehydration?

Episode 1 _____

Episode 2 _____

Episode 3 _____

We are interested in getting some more information about your child's current stool patterns.

32. How many stools does your child have per day? Would you say it is…
- □ 0 – 1 stools
- □ 2 – 3 stools
- □ more than 3 stools
- □ Don't know

33. How many stools does your child have per week? Would you say it is…
- □ fewer than 3 stools
- □ 3 – 7 stools
- □ more than 7 stools
- □ Don't know

34. Does your child currently wear diapers?
- □ Yes (*go to question 35 and refer to LIST A*)
- □ No (*go to question 35 and refer to LIST B*)
- □ Don't know

35. What is the typical consistency of your child's stools? Would you say it is…

LIST A (use this list if your child wears diapers)
- □ Separate hard lumps, like nuts or rabbit pellets
- □ Sausage-shaped but lumpy
- □ Like a sausage or snake but with cracks on its surface, form may be changed slightly by sitting on stool
- □ Like a sausage or snake, smooth and soft, may be deformed by sitting on stool
- □ Soft blobs with clear cut edges, never a sausage
- □ Runny, no form
- □ Watery, no solid pieces, soaks into diaper
- □ Don't know

LIST B (use this list if your child does <u>not</u> wear diapers)

- ☐ Separate hard lumps, like nuts
- ☐ Sausage-shaped but lumpy
- ☐ Like a sausage or snake but with cracks on its surface
- ☐ Like a sausage or snake, smooth and soft
- ☐ Soft blobs with clear-cut edges
- ☐ Fluffy pieces with ragged edges, a mushy stool
- ☐ Watery, no solid pieces
- ☐ Don't know

36. Are your child's stools like separate hard lumps, fluffy pieces with ragged edges (mushy stool), or watery with no solid pieces two or more times per week?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

37. Does your child alternate between loose stools and hard stools?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know