

Rome III
Diagnostic
Questionnaire for
the Pediatric
Functional GI
Disorders

Preamble

The Questionnaire on Pediatric Gastrointestinal Symptoms—Rome III Version (QPGS-RIII)* is an adaptation and abbreviation of the Questionnaire on Pediatric Gastrointestinal Symptoms (QPGS) (Walker, Caplan-Dover, & Rasquin-Weber, 2000; Walker et al., 2005) that was developed with the support of a grant from the Rome Foundation and that has undergone preliminary validation (Caplan, Walker, & Rasquin, 2005a, b). The original QPGS assesses the Rome II symptom criteria for pediatric functional gastrointestinal disorders and additional gastrointestinal symptoms. The QPGS-RIII is an adaptation and abbreviation of the original QPGS. It was developed with input from the Rome III Child and Adolescent Committee and the Rome III Questionnaire Committee. Although the format and many items from the original QPGS have been retained, several new items have been included and the scoring has been revised to reflect changes in symptom criteria based on Rome III. Some items included in the original QPGS for research purposes have been deleted from the QPGS-RIII for brevity.

The parent-report version of the QPGS-RIII is suitable for use by parents of children four years of age and older. The self-report version is suitable for administration to children ten years of age and older and is preferable to the parent-report version when parents have limited knowledge of their children's symptoms. The questionnaire uses 5-point scales to measure frequency, severity, and duration of symptoms. In addition, it may be scored to assess whether a patient meets the criteria for each of the individual functional gastrointestinal disorders.

The questionnaire is followed by a coding system that identifies provisional diagnoses from the responses to the questions. The QPGS-RIII cannot substitute for the medical evaluation and clinical judgment required for an accurate diagnosis.

* Developed by Lynn S. Walker, Arlene Caplan, and Andrée Rasquin

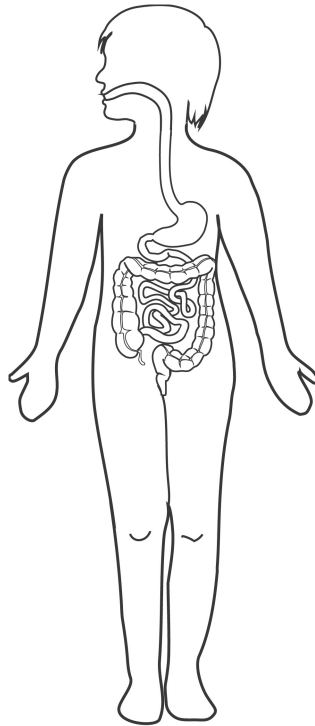
References

- Caplan, A., Walker, L. S., & Rasquin, A. (2005). Development and preliminary validation of the Questionnaire on Pediatric Gastrointestinal Symptoms to assess functional gastrointestinal disorders in children and adolescents. *J Pediatric Gastroenterol Nutrition*, 4, 296–304.
- Caplan, A., Walker, L. S., & Rasquin, A. (2005). Validation of the Pediatric Rome II Criteria for functional gastrointestinal symptoms using the Questionnaire on Pediatric Gastrointestinal Symptoms. *J Pediatric Gastroenterol Nutrition*, 41, 305–316.
- Walker, L. S., Lipani, T. A., Greene, J. W., Caines, K., Stutts, J., Polk, D. B., Caplan, A., & Rasquin-Weber, A. (2004). Recurrent abdominal pain: Subtypes based on the Rome II criteria for pediatric functional gastrointestinal disorders. *J Pediatric Gastroenterol Nutrition*, 38, 187–191.
- Walker, L. S., Caplan, A., & Rasquin, A. (2000). *Manual for the Questionnaire on Pediatric Gastrointestinal Symptoms*. Nashville, TN: Department of Pediatrics, Vanderbilt University Medical Center.

PARENT-REPORT FORM CHILDREN 4 YEARS OF AGE AND OLDER

Questionnaire on Pediatric Gastrointestinal Symptoms, Rome III Version (QPGS-RIII)

(Adapted from the Questionnaire on Pediatric Gastrointestinal Symptoms,
Walker, Caplan-Dover, & Rasquin-Weber, 2000)



Instructions

This questionnaire is about your child's digestive system (esophagus, stomach, small intestine, and colon) and problems you can have with it. Certain problems may apply to your child and others will not.

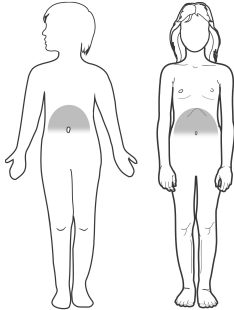
Please try to answer *all* of the questions as best as you can. If it is *impossible* for you to answer a particular question, please answer "I don't know" where indicated.

If you have any questions, the research assistant will be glad to help!

PARENT-REPORT FORM CHILDREN 4 YEARS OF AGE AND OLDER

Section A. Pain and Uncomfortable Feelings In the Upper Abdomen Above the Belly Button

The shaded area in the pictures below shows an area ABOVE your child's belly button where children sometimes hurt, feel pain, or have an uncomfortable feeling. Some words for these feelings are stomachaches, nausea, bloating, a feeling of fullness, or not being hungry after eating very little.



Above the Belly Button

The questions in this section are about pain and uncomfortable feelings ABOVE the belly button that your child may have had in the last 2 months. Children can have pain and uncomfortable feelings in more than one area of the belly. In a different section of the questionnaire, you will be asked about the areas around and below your child's belly button.

1. In the last 2 months, how often did your child have pain or an uncomfortable feeling in the upper abdomen *above the belly button*?
 0. Never
 1. 1 to 3 times a month
 2. Once a week
 3. Several times a week
 4. Every day

If your child has not had ANY pain or uncomfortable feelings above the belly button in the past 2 months, please go to Section B.

2. Which of the following feelings did your child have *above the belly button*? (You may check one or more than one.)

a. Pain	o. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes
b. Nausea	o. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes
c. Bloating	o. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes
d. Feeling of fullness	o. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes
e. Not being hungry after eating very little	o. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes

PARENT-REPORT FORM CHILDREN 4 YEARS OF AGE AND OLDER

3. In the last 2 months, how much did your child hurt or feel uncomfortable *above the belly button*?
 1. ___ A little
 2. ___ Some (between a little and a lot)
 3. ___ A lot
 4. ___ A very lot
 - ___ I don't know

4. When your child hurt or felt uncomfortable *above the belly button*, for how long did it last?
 1. ___ Less than an hour
 2. ___ 1 to 2 hours
 3. ___ 3 to 4 hours
 4. ___ Most of the day
 5. ___ All the time

5. For how long has your child had pain or an uncomfortable feeling *above the belly button*?
 1. ___ 1 month or less
 2. ___ 2 months
 3. ___ 3 months
 4. ___ 4 to 11 months
 5. ___ 1 year or longer

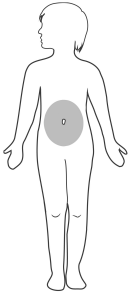
PARENT-REPORT FORM CHILDREN 4 YEARS OF AGE AND OLDER

<i>Circle a number for your answer to each question below.</i>	0% of the time	25% of the time	50% of the time	75% of the time	100% of the time	I don't know
In the last 2 months, when your child hurt or felt uncomfortable above the belly button, how often	Never	Once in a while	Sometimes	Most of the time	Always	(check box)
6. Did the hurt or uncomfortable feeling get better after your child had a poop?	0	1	2	3	4	<input type="checkbox"/>
7. Were your child's poops softer and more mushy or watery than usual?	0	1	2	3	4	<input type="checkbox"/>
8. Were your child's poops harder or lumpier than usual?	0	1	2	3	4	<input type="checkbox"/>
9. Did your child have more poops than usual?	0	1	2	3	4	<input type="checkbox"/>
10. Did your child have fewer poops than usual?	0	1	2	3	4	<input type="checkbox"/>
11. Did your child feel bloated in the belly?	0	1	2	3	4	<input type="checkbox"/>
12. Did your child have a headache?	0	1	2	3	4	<input type="checkbox"/>
13. Did your child have difficulty sleeping?	0	1	2	3	4	<input type="checkbox"/>
14. Did your child have pain in the arms, legs, or back?	0	1	2	3	4	<input type="checkbox"/>
15. Did your child feel faint or dizzy?	0	1	2	3	4	<input type="checkbox"/>
16. Did your child miss school or stop activities?	0	1	2	3	4	<input type="checkbox"/>

PARENT-REPORT FORM CHILDREN 4 YEARS OF AGE AND OLDER

Section B. Belly Aches and Abdominal Pain Around and Below the Belly Button

The questions in this section are about the areas AROUND and BELOW your child's belly button. These areas are shown shaded in the pictures below. Children sometimes have a belly ache or pain in these areas. Belly aches are sometimes milder than pain. Some children call their belly aches or pains "stomach aches" or "tummy aches."



Around the Belly Button



Below the Belly Button

1. In the last 2 months, how often did your child have a belly ache or pain *in the area around or below the belly button*?
 0. ___ Never
 1. ___ 1 to 3 times a month
 2. ___ Once a week
 3. ___ Several times a week
 4. ___ Every day

If your child has not had ANY belly aches or pain in the areas around or below the belly button in the past 2 months, please go to Section C.

2. In the last 2 months, how much did your child usually hurt *in the area around or below the belly button*?
 1. ___ A little
 2. ___ Some (between a little and a lot)
 3. ___ A lot
 4. ___ A very lot
 - ___ I don't know

PARENT-REPORT FORM CHILDREN 4 YEARS OF AGE AND OLDER

3. When your child hurt or felt uncomfortable *around or below the belly button*, for how long did it last?
1. ___ Less than an hour
 2. ___ 1 to 2 hours
 3. ___ 3 to 4 hours
 4. ___ Most of the day
 5. ___ All the time
4. For how long has your child had belly aches or pain *around or below the belly button*?
1. ___ 1 month or less
 2. ___ 2 months
 3. ___ 3 months
 4. ___ 4 to 11 months
 5. ___ 1 year or longer

<i>Circle a number for your answer to each question below.</i>	0% of the time	25% of the time	50% of the time	75% of the time	100% of the time	I don't know (check box)
In the last 2 months, when your child had a belly ache or pain around or below the bellow button, how often	Never	Once in a while	Sometimes	Most of the time	Always	
5. Did it get better after having a poop?	0	1	2	3	4	<input type="checkbox"/>
6. Were your child's poops softer and more mushy or watery than usual?	0	1	2	3	4	<input type="checkbox"/>
7. Were your child's poops harder or lumpier than usual?	0	1	2	3	4	<input type="checkbox"/>
8. Did your child have more poops than usual?	0	1	2	3	4	<input type="checkbox"/>
9. Did your child have fewer poops than usual?	0	1	2	3	4	<input type="checkbox"/>
10. Did your child feel bloated in the belly?	0	1	2	3	4	<input type="checkbox"/>
11. Did your child have a headache?	0	1	2	3	4	<input type="checkbox"/>

PARENT-REPORT FORM CHILDREN 4 YEARS OF AGE AND OLDER

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

This section asks about your child’s bowel movements. There are many words for bowel movements, such as “poop,” “stool,” “BMs,” and “going to the bathroom for number 2.” Your family may use another special word when they talk about poops.

1. In the last 2 months, how often did your child usually have poops?
 1. 2 times a week or less often
 2. 3 to 6 times a week
 3. Once a day
 4. 2 to 3 times a day
 5. More than 3 times a day
 - I don’t know

2. In the last 2 months, what was your child’s poop usually like?
 1. Very hard
 2. Hard
 3. Not too hard and not too soft
 4. Very soft or mushy
 5. Watery
 6. It depends (his/her poops are not always the same)
 - I don’t know

2a. If your child’s poops were usually hard, for how long have they been hard?

 0. Less than 1 month
 1. 1 month
 2. 2 months
 3. 3 or more months

3. In the last 2 months, did it hurt when your child had a poop?
 0. No
 1. Yes
 - I don’t know

PARENT-REPORT FORM CHILDREN 4 YEARS OF AGE AND OLDER

<i>Circle a number for your answer to each question below.</i>	0% of the time	25% of the time	50% of the time	75% of the time	100% of the time	I don't know
In the last 2 months, how often	Never	Once in a while	Sometimes	Most of the time	Always	(check box)
4. Did your child have to rush to the bathroom to poop?	0	1	2	3	4	<input type="checkbox"/>
5. Did your child have to strain (push hard) to make a poop come out?	0	1	2	3	4	<input type="checkbox"/>
6. Did your child pass mucus or phlegm (white, yellowish, stringy, or slimy material) during a poop?	0	1	2	3	4	<input type="checkbox"/>
7. Did your child have a feeling of not being finished after a poop (like there was more that wouldn't come out)?	0	1	2	3	4	<input type="checkbox"/>

8. In the last 2 months, did your child have a poop that was so big that it clogged the toilet?

0. ___ No
1. ___ Yes

9. Some children hold in their poop even when there is a toilet available. They may do this by stiffening their bodies or crossing their legs. In the last 2 months, while at home, how often did your child try to hold in a poop?

0. ___ Never
1. ___ 1 to 3 times a month
2. ___ Once a week
3. ___ Several times a week
4. ___ Every day

10. Did a doctor or nurse ever examine your child and say that your child had a huge poop inside?

0. ___ No
1. ___ Yes

PARENT-REPORT FORM CHILDREN 4 YEARS OF AGE AND OLDER

11. In the last 2 months, how often was your child's underwear stained or soiled with poop?

0. ___ Never. *If never, please go to Section D.*
1. ___ Less than once a month
2. ___ 1 to 3 times a month
3. ___ Once a week
4. ___ Several times a week
5. ___ Every day

11a. When your child stained or soiled underwear, how much was it stained or soiled?

1. ___ Underwear was stained (no poop)
2. ___ Small amount of poop in underwear (less than a whole poop)
3. ___ Large amount of poop in underwear (a whole poop)

11b. For how long has your child stained or soiled underwear?

1. ___ 1 month or less
2. ___ 2 months
3. ___ 3 months
4. ___ 4 to 11 months
5. ___ 1 year or longer

Section D. Other Symptoms

<i>Circle a number for your answer to each question below.</i>	0% of the time	25% of the time	50% of the time	75% of the time	100% of the time	I don't know
In the last 2 months, how often did your child	Never	Once in a while	Sometimes	Most of the time	Always	(check box)
1. Burp (belch) <i>again and again</i> without wanting to?	0	1	2	3	4	<input type="checkbox"/>
2. Pass a lot of gas <i>very frequently</i> ?	0	1	2	3	4	<input type="checkbox"/>
3. Develop a clearly swollen belly during the day (you could see it was swollen)?	0	1	2	3	4	<input type="checkbox"/>
4. Swallow or gulp extra air? (You might hear a clicking noise when your child swallows.)	0	1	2	3	4	<input type="checkbox"/>

PARENT-REPORT FORM CHILDREN 4 YEARS OF AGE AND OLDER

5. IN THE PAST YEAR, how many times did your child vomit (throw up) *again and again without stopping for 2 hours or longer?*
0. Never. *If never, please go to Section E.*
 1. Once
 2. 2 times
 3. 3 times
 4. 4 or more times
- 5a. For how long has your child had episodes of vomiting again and again without stopping?
1. 1 month or less
 2. 2 months
 3. 3 months
 4. 4 to 11 months
 5. 1 year or longer
- 5b. Did your child usually feel nausea when he or she vomited again and again without stopping?
0. No
 1. Yes
- 5c. Was your child in good health for several weeks or longer between the episodes of vomiting again and again?
0. No
 1. Yes
6. In the past 2 months, how often did food come back up into your child's mouth after eating?
0. Never. *If never, please go to Section E.*
 1. 1 to 3 times a month
 2. Once a week
 3. Several times a week
 4. Every day
- 6a. Does this usually happen less than an hour after your child eats?
0. No
 1. Yes

**PARENT-REPORT FORM
CHILDREN 4 YEARS OF AGE AND OLDER**

6b. Does food come back up into your child's mouth while your child is sleeping?

0. No

1. Yes

6c. Does your child usually feel nausea and vomit when food comes back up into his or her mouth?

0. No

1. Yes

6d. Does it usually hurt your child when the food comes back up into his or her mouth?

0. No

1. Yes

6e. What does your child usually do with the food that comes back up into his or her mouth?

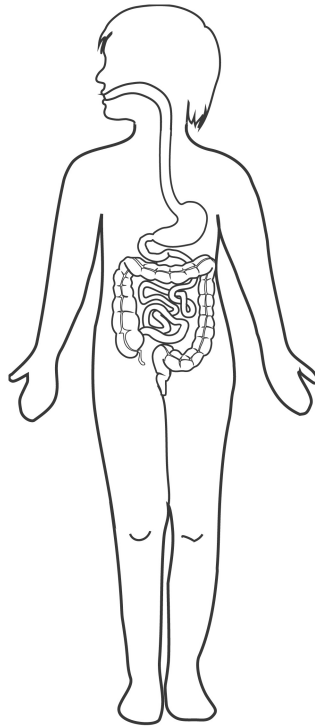
0. Swallow it.

1. Spit it out.

SELF-REPORT FORM FOR CHILDREN AND ADOLESCENTS (10 YEARS OF AGE AND OLDER)

Questionnaire on Pediatric Gastrointestinal Symptoms, Rome III Version (QPGS-RIII)

(Adapted from the Questionnaire on Pediatric Gastrointestinal Symptoms,
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Instructions

This questionnaire is about your digestive system (esophagus, stomach, small intestine, and colon) and problems you can have with it. Certain problems may apply to you and others will not.

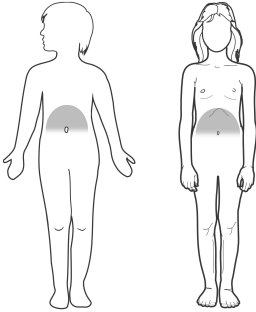
Please try to answer *all* of the questions as best as you can.

If you have any questions, the research assistant will be glad to help!

SELF-REPORT FORM FOR CHILDREN AND ADOLESCENTS (10 YEARS OF AGE AND OLDER)

Section A. Pain and Uncomfortable Feelings In the Upper Abdomen Above the Belly Button

The shaded area in the pictures below shows an area ABOVE your belly button where children sometimes hurt, feel pain, or have an uncomfortable feeling. Some words for these feelings are stomachaches, nausea, bloating, a feeling of fullness, or not being hungry after eating very little.



Above the Belly Button

The questions in this section are about pain and uncomfortable feelings ABOVE the belly button that you may have had in the last 2 months. Children can have pain and uncomfortable feelings in more than one area of the belly. In a different section of the questionnaire, you will be asked about the areas around and below your belly button.

1. In the last 2 months, how often did you have pain or an uncomfortable feeling in the upper abdomen *above the belly button*?
 0. Never
 1. 1 to 3 times a month
 2. Once a week
 3. Several times a week
 4. Every day

If you have not had ANY pain or uncomfortable feelings above the belly button in the past 2 months, please go to Section B.

2. Which of the following feelings did you have *above the belly button*? (You may check one or more than one.)

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

SELF-REPORT FORM FOR CHILDREN AND ADOLESCENTS (10 YEARS OF AGE AND OLDER)

3. In the last 2 months, how much did you hurt or feel uncomfortable *above the belly button*?
 1. ___ A little
 2. ___ Some (between a little and a lot)
 3. ___ A lot
 4. ___ A very lot

4. When you hurt or felt uncomfortable *above the belly button*, for how long did it last?
 1. ___ Less than an hour
 2. ___ 1 to 2 hours
 3. ___ 3 to 4 hours
 4. ___ Most of the day
 5. ___ All the time

5. For how long have you had pain or an uncomfortable feeling *above the belly button*?
 1. ___ 1 month or less
 2. ___ 2 months
 3. ___ 3 months
 4. ___ 4 to 11 months
 5. ___ 1 year or longer

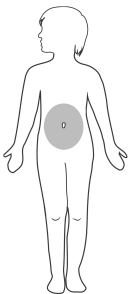
SELF-REPORT FORM FOR CHILDREN AND ADOLESCENTS (10 YEARS OF AGE AND OLDER)

<i>Circle a number for your answer to each question below.</i>	0% of the time	25% of the time	50% of the time	75% of the time	100% of the time
In the last 2 months, when you hurt or felt uncomfortable above the belly button, how often	Never	Once in a while	Sometimes	Most of the time	Always
6. Did the hurt or uncomfortable feeling get better after you had a poop?	0	1	2	3	4
7. Were your poops softer and more mushy or watery than usual?	0	1	2	3	4
8. Were your poops harder or lumpier than usual?	0	1	2	3	4
9. Did you have more poops than usual?	0	1	2	3	4
10. Did you have fewer poops than usual?	0	1	2	3	4
11. Did you feel bloated in your belly?	0	1	2	3	4
12. Did you have a headache?	0	1	2	3	4
13. Did you have difficulty sleeping?	0	1	2	3	4
14. Did you have pain in the arms, legs, or back?	0	1	2	3	4
15. Did you feel faint or dizzy?	0	1	2	3	4
16. Did you miss school or stop activities?	0	1	2	3	4

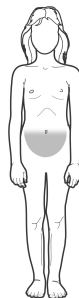
SELF-REPORT FORM FOR CHILDREN AND ADOLESCENTS (10 YEARS OF AGE AND OLDER)

Section B. Belly Aches and Abdominal Pain Around and Below the Belly Button

The questions in this section are about the areas AROUND and BELOW your belly button. These areas are shown shaded in the pictures below. Children sometimes have a belly ache or pain in these areas. Belly aches are sometimes milder than pain. Some children call their belly aches or pains “stomach aches” or “tummy aches.”



Around the Belly Button



Below the Belly Button

1. In the last 2 months, how often did you have a belly ache or pain *in the area around or below the belly button*?
 0. Never
 1. 1 to 3 times a month
 2. Once a week
 3. Several times a week
 4. Every day

If you have not had ANY belly aches or pain in the areas around or below the belly button in the past 2 months, please go to Section C.

2. In the last 2 months, how much did you usually hurt *in the area around or below the belly button*?
 1. A little
 2. Some (between a little and a lot)
 3. A lot
 4. A very lot

SELF-REPORT FORM FOR CHILDREN AND ADOLESCENTS (10 YEARS OF AGE AND OLDER)

3. When you hurt or felt uncomfortable *around or below the belly button*, for how long did it last?
1. ___ Less than an hour
 2. ___ 1 to 2 hours
 3. ___ 3 to 4 hours
 4. ___ Most of the day
 5. ___ All the time
4. For how long have you had belly aches or pain *around or below the belly button*?
1. ___ 1 month or less
 2. ___ 2 months
 3. ___ 3 months
 4. ___ 4 to 11 months
 5. ___ 1 year or longer

<i>Circle a number for your answer to each question below.</i>	0% of the time	25% of the time	50% of the time	75% of the time	100% of the time
In the last 2 months, when you had a belly ache or pain around or below the bellow button, how often	Never	Once in a while	Sometimes	Most of the time	Always
5. Did it get better after having a poop?	0	1	2	3	4
6. Were your poops softer and more mushy or watery than usual?	0	1	2	3	4
7. Were your poops harder or lumpier than usual?	0	1	2	3	4
8. Did you have more poops than usual?	0	1	2	3	4
9. Did you have fewer poops than usual?	0	1	2	3	4
10. Did you feel bloated in the belly?	0	1	2	3	4
11. Did you have a headache?	0	1	2	3	4

SELF-REPORT FORM FOR CHILDREN AND ADOLESCENTS (10 YEARS OF AGE AND OLDER)

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

This section asks about your bowel movements. There are many words for bowel movements, such as “poop,” “stool,” “BMs,” and “going to the bathroom for number 2.” Your family may use another special word when they talk about poops.

1. In the last 2 months, how often did you usually have poops?
 1. ___ 2 times a week or less often
 2. ___ 3 to 6 times a week
 3. ___ Once a day
 4. ___ 2 to 3 times a day
 5. ___ More than 3 times a day

2. In the last 2 months, what was your poop usually like?
 1. ___ Very hard
 2. ___ Hard
 3. ___ Not too hard and not too soft
 4. ___ Very soft or mushy
 5. ___ Watery
 6. ___ It depends (my poops are not always the same)
 - 2a. If your poops were usually hard, for how long have they been hard?
 0. ___ Less than 1 month
 1. ___ 1 month
 2. ___ 2 months
 3. ___ 3 or more months

3. In the last 2 months, did it hurt when you had a poop?
 0. ___ No
 1. ___ Yes

SELF-REPORT FORM FOR CHILDREN AND ADOLESCENTS (10 YEARS OF AGE AND OLDER)

<i>Circle a number for your answer to each question below.</i>	0% of the time	25% of the time	50% of the time	75% of the time	100% of the time
In the last 2 months, how often	Never	Once in a while	Sometimes	Most of the time	Always
4. Did you have to rush to the bathroom to poop?	0	1	2	3	4
5. Did you have to strain (push hard) to make a poop come out?	0	1	2	3	4
6. Did you pass mucus or phlegm (white, yellowish, stringy, or slimy material) during a poop?	0	1	2	3	4
7. Did you have a feeling of not being finished after a poop (like there was more that wouldn't come out)?	0	1	2	3	4

8. In the last 2 months, did you have a poop that was so big that it clogged the toilet?

- 0. No
- 1. Yes

9. Some children hold in their poop even when there is a toilet they could use. They may do this by stiffening their bodies or crossing their legs. In the last 2 months, while at home, how often did you try to hold in a poop?

- 0. Never
- 1. 1 to 3 times a month
- 2. Once a week
- 3. Several times a week
- 4. Every day

10. Did a doctor or nurse ever examine you and say that you had a huge poop inside?

- 0. No
- 1. Yes

SELF-REPORT FORM FOR CHILDREN AND ADOLESCENTS (10 YEARS OF AGE AND OLDER)

11. In the last 2 months, how often was your underwear stained or soiled with poop?

- 0. ___ Never. *If never, please go to Section D.*
- 1. ___ Less than once a month
- 2. ___ 1 to 3 times a month
- 3. ___ Once a week
- 4. ___ Several times a week
- 5. ___ Every day

11a. When you stained or soiled underwear, how much was it stained or soiled?

- 1. ___ Underwear was stained (no poop)
- 2. ___ Small amount of poop in underwear (less than a whole poop)
- 3. ___ Large amount of poop in underwear (a whole poop)

11b. For how long have you stained or soiled your underwear?

- 1. ___ 1 month or less
- 2. ___ 2 months
- 3. ___ 3 months
- 4. ___ 4 to 11 months
- 5. ___ 1 year or longer

Section D. Other Symptoms

<i>Circle a number for your answer to each question below.</i>	0% of the time	25% of the time	50% of the time	75% of the time	100% of the time
In the last 2 months, how often did you	Never	Once in a while	Sometimes	Most of the time	Always
1. Burp (belch) <i>again and again</i> without wanting to?	0	1	2	3	4
2. Pass a lot of gas <i>very frequently</i> ?	0	1	2	3	4
3. Develop a clearly swollen belly during the day (you could see it was swollen)?	0	1	2	3	4
4. Swallow or gulp extra air? (You might hear a clicking noise when you swallow.)	0	1	2	3	4

**SELF-REPORT FORM FOR CHILDREN AND
ADOLESCENTS (10 YEARS OF AGE AND OLDER)**

5. IN THE PAST YEAR, how many times did you vomit (throw up) *again and again without stopping for 2 hours or longer*?
- 0. Never
 - 1. Once
 - 2. 2 times
 - 3. 3 times
 - 4. 4 or more times
- 5a. For how long have you had episodes of vomiting again and again without stopping?
- 1. 1 month or less
 - 2. 2 months
 - 3. 3 months
 - 4. 4 to 11 months
 - 5. 1 year or longer
- 5b. Did you usually feel nausea when you vomited again and again without stopping?
- 0. No
 - 1. Yes
- 5c. Were you in good health for several weeks or longer between the episodes of vomiting again and again?
- 0. No
 - 1. Yes
6. In the past 2 months, how often did food come back up into your mouth after eating?
- 0. Never
 - 1. 1 to 3 times a month
 - 2. Once a week
 - 3. Several times a week
 - 4. Every day
- 6a. Does this usually happen less than an hour after you eat?
- 0. No
 - 1. Yes

**SELF-REPORT FORM FOR CHILDREN AND
ADOLESCENTS (10 YEARS OF AGE AND OLDER)**

6b. Does food come back up into your mouth while you are sleeping?

0. No

1. Yes

6c. Do you usually feel nausea and vomit when food comes back up into your mouth?

0. No

1. Yes

6d. Does it usually hurt when the food comes back up into your mouth?

0. No

1. Yes

6e. What do you usually do with the food that comes back up into your mouth?

0. Swallow it.

1. Spit it out.

SCORING INSTRUCTIONS FOR PARENT-REPORT FORM AND CHILD/ADOLESCENT SELF-REPORT FORM

Questionnaire on Pediatric Gastrointestinal Symptoms, Rome III Version (QPGS-RIII)

(Adapted from the Questionnaire on Pediatric Gastrointestinal Symptoms,
Walker, Caplan-Dover, & Rasquin-Weber, 2000)

Scoring Instructions for Parent-report Form and Child/Adolescent Self-report Form

Note. Items are labeled by section (e.g., A1 is item #1 in Section A of the QPGS-RIII). For each disorder, the patient must meet the criteria for all items indicated. Cut-points for symptom frequencies to meet diagnostic criteria are based on provisional recommendations by the Rome III Child and Adolescent Committee).

I. Functional Dyspepsia

- (A 1) Upper abdominal pain or discomfort “several times a week” or more often
- (A 5) Duration of upper abdominal pain or discomfort is “2 months” or longer
- (A 6) Not exclusively relieved with defecation; A6 is “sometimes” or less often
- Not associated with change in stool form: “never” or “once in a while” indicated for
 - (A 7) softer stools **and** (A 8) harder stools
- Not associated with change in stool frequency: “never” or “once in a while” indicated for
 - (A 9) more stools **and** (A 10) fewer stools

SCORING INSTRUCTIONS FOR PARENT-REPORT FORM AND CHILD/ADOLESCENT SELF-REPORT FORM

II. Irritable Bowel Syndrome

Lower abdominal pain associated with bowel symptoms

- (B 1) Periumbilical/lower abdominal pain/discomfort “once a week” or more often
- (B 4) Duration of periumbilical/lower abdominal pain/discomfort is “2 months” or longer
- At least two of the following “sometimes” or more often:
 - (B 5) Relief with defecation
 - Change in bowel movement form: (B 6) softer **or** (B 7) harder
 - Change in bowel movement frequency: (B 8) more **or** (B 9) fewer

AND/OR

Upper abdominal pain associated with bowel symptoms

- (A 1) Upper abdominal pain or discomfort “once a week” or more often
- (A 5) Duration of upper abdominal pain/discomfort is “2 months” or longer
- At least two of the following “sometimes” or *more* often:
 - (A 6) Relief with defecation
 - Change in bowel movement form: (A 7) softer **or** (A 8) harder
 - Change in bowel movement frequency: (A 9) more **or** (A 10) fewer

Note. Additional symptoms suggestive of IBS but not required: C4, C5, C6, C7.

III. Abdominal Migraine

- (B16) In the past year, 2 or more episodes of severe pain lasting 1 hour or longer and causing restriction in daily activities
- (B16a) Two or more of the following during episodes:
 - a. No appetite
 - b. Nausea
 - c. Vomiting
 - d. Pale skin
 - e. Headache
 - f. Eyes sensitive to light
- (B 16b) Symptom-free periods between pain episodes (“yes”)

SCORING INSTRUCTIONS FOR PARENT-REPORT FORM AND CHILD/ADOLESCENT SELF-REPORT FORM

IV. Functional Abdominal Pain

Lower abdominal location

- (B1) Periumbilical/lower abdominal pain “once a week” or more often
- (B4) Duration of abdominal pain is “2 months” or longer
- Does not meet criteria for other functional gastrointestinal disorders associated with abdominal pain (functional dyspepsia, IBS, abdominal migraine, functional abdominal pain syndrome).

Upper abdominal location

- (A1) Upper abdominal pain “once a week” or more often
- (A5) Duration of abdominal pain is “2 months” or longer
- Does not meet criteria for other functional gastrointestinal disorders associated with abdominal pain (functional dyspepsia, IBS, abdominal migraine, functional abdominal pain syndrome).

V. Functional Abdominal Pain Syndrome

Lower abdominal location

- (B1) Periumbilical/lower abdominal pain “several times a week” or more often
- (B4) Duration of abdominal pain is “2 months” or longer
- EITHER Two or more other somatic symptoms “once a week” or more often
 - (B11) Headache
 - (B12) Difficulty sleeping
 - (B13) Pain in arms, legs, or back
 - (B14) Faint or dizzy

OR (B15) Misses activities “once in a while” or more often

- Does not meet criteria for other functional gastrointestinal disorders associated with abdominal pain (functional dyspepsia, irritable bowel syndrome, abdominal migraine)

Upper abdominal location

- (A1) Upper abdominal pain “several times a week” or more often
- (A5) Duration of abdominal pain is “2 months” or longer
- EITHER Two or more other somatic symptoms “once a week” or more often
 - (A12) Headache
 - (A13) Difficulty sleeping
 - (A14) Pain in arms, legs, or back
 - (A15) Faint or dizzy

OR (A16) Misses activities “once in a while” or more often

- Does not meet criteria for other functional gastrointestinal disorders associated with abdominal pain (functional dyspepsia, irritable bowel syndrome, abdominal migraine)

SCORING INSTRUCTIONS FOR PARENT-REPORT FORM AND CHILD/ADOLESCENT SELF-REPORT FORM

VI. Functional Constipation

- Two or more of the following:
 - (C 1) Two or fewer stools per week
 - Either** (C2) hard or very hard stools **or** (C3) painful stool
 - (C8) Passage of very large stool
 - (C9) Stool retention “once a week” or more often
 - (C10) History of large fecal mass in rectum
 - (C11) Soiling “once a week” or more often
- Does not meet criteria for irritable bowel syndrome

VII. Nonretentive Fecal Incontinence

- Child is 4 years of age or older
- (C11) Soiling “once a week” or more often
- (C11a) Amount of stool is small or large (not just a stain)
- (C11b) Soiling for 2 months or longer
- No evidence of fecal retention (does not meet criteria for functional constipation)

VIII. Aerophagia

- Two or more of the following are “several times a week” or “every day”:
 - Either:** (D1) belching **or** (D2) flatus
 - (D3) Abdominal distention
 - (D4) Swallowing air

X. Cyclic Vomiting Syndrome

- (D 5) Three or more episodes of repeated vomiting in the past year
- (D 5a) Duration is 2 months or longer
- (D 5b) Presence of nausea is “yes”
- (D 5c) Occurrence of wellness intervals is “yes”

IX. Adolescent Rumination Syndrome

- (D6) Food comes back up “several times a week” or “every day.”
- (D6a) Episodes occur shortly after eating (“Yes”)
- (D6b) Episodes do not occur during sleep (“No”)
- (D6c) Episodes are not accompanied by nausea or vomiting (“No”)
- (D6d) Episodes are not painful (“No”)