Autism Treatment Network GI Signs & Symptoms Inventory-17 (ATN-GISSI-17)

Child's Name _____ Today's Date: __ __ / __ __ / 2 0 __ __

Child's Gender _____ Age ____ years Child's Date of Birth __ __ / __ __ / __ __ __ __

Your relationship to this child: ☐ Mother ☐ Father ☐Other: _____

Most of the questions on this form are about THE LAST THREE MONTHS.
Please put a check (✓) in the box that best describes your child.

	Yes	No	Unsure
In the last 3 months, has your child experienced any of the following gastrointestinal (tummy) symptoms:			
1. Abdominal (belly) pain	☐	☐	☐
2. Nausea	☐	☐	☐
3. **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?	☐	☐	☐

4. **In the last 3 months,** how often did your child usually have BMs?
   - a. ☐ Less than once a week
   - b. ☐ 1-2 Times a week
   - c. ☐ 3-6 Times a week
   - d. ☐ Once a day
   - e. ☐ 2-3 Times a day
   - f. ☐ More than 3 times a day
   - g. ☐ Unsure

5. **In the last 3 months**, what were your child's BMs usually like?
   - a. ☐ Very hard
   - b. ☐ Hard
   - c. ☐ Not too hard and not too soft
   - d. ☐ Very soft or mushy
   - e. ☐ Watery
   - f. ☐ Unsure

In the last 3 months, did your child:	Yes	No	Unsure
6. Appear to feel pain when having a BM?	☐	☐	☐
7. Have to rush to the bathroom for a BM?	☐	☐	☐
8. **Has your child ever** had a black, tarry BM?	☐	☐	☐

In the last 3 months, has your child:	Yes	No	Unsure

9. Spit up ≥ 2x per day?	☐	☐	☐
10. Experienced retching?	☐	☐	☐
11. Tilted his/her head to the side and arched back?	☐	☐	☐
<u>In the last 3 months,</u> has your child missed activities due to:			
12. pain and/or discomfort?	☐	☐	☐
13. vomiting	☐	☐	☐
14. problems with BMs	☐	☐	☐
15. **<u>In the last 3 months,</u>** did your child push his abdomen with his/her hands or your hands, push his/her abdomen against or lean forward over furniture?	☐	☐	☐
16. **<u>In the last 3 months,</u>** did your child choke, gag, cough, or sound wet during or after swallowing or with meals?	☐	☐	☐
17. **<u>In the last 3 months,</u>** has your child started to refuse many foods that he or she would eat in the past?	☐	☐	☐

ATN-GISSI-17 Score Sheet

Directions: For any "yes" or checked response above, place a ✓ next to the corresponding item number in the columns below.

Constipation	**Diarrhea**	**GERD**	**GERD**
1. _____	2. _____	2. _____	3. _____
4a. _____	5d. _____	9. _____	11. _____
4b. _____	5e. _____	10. _____	15. _____
5a. _____	7. _____	13. _____	17. _____
5b. _____	8. _____	16. _____	
6. _____	11. _____		
12. _____	14. _____		
14. _____	17. _____		
17. _____			
✓ in column above? if yes, then screen positive for **constipation**	✓in the column above? if yes, then screen positive for **diarrhea**	✓ in the column above? if yes, then screen positive for **GERD**	2 or more ✓ in the column above? Then also screen positive for **GERD**