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PARDI-AR-Q: Parent 4+

The following questions are about your child's eating – some ask about how things currently are, others ask about things over the past month or the past 3 months. Please tick the boxes that apply, or enter the information requested. **Please read each question carefully. Please answer all the questions. Thank you.**

1. Please fill in today's date: ____/_____/_____ (day/month/year)

2. Please fill in your child's date of birth: ____/_____/_____ (day/month/year)

3. Is your child? Male ☐ Female ☐ Other ☐ _____

4. What is your child's height? (please enter numbers): feet ☐ in ☐ **/OR** metres ☐ cm ☐

5. What is your child's weight? (please enter numbers): lbs ☐ **/OR** stones ☐ lbs ☐ **/OR** kg ☐

6. Do you think your child has a problem with eating, involving avoidance or restriction of foods or their eating overall? Yes ☐ No ☐

7. Have other people (for example, doctors, family members, significant others) said that your child has a problem with eating, involving avoidance or restriction of foods or their eating overall? Yes ☐ No ☐

8. Have your child's eating habits led to difficulty maintaining a sufficient weight or, if they are still growing, difficulty gaining enough weight to keep pace with their growth? Yes ☐ No ☐

9. Have your child's eating habits led to them losing weight (in other words, if they have lost weight, this is because of avoidance or restriction and not because of a medical illness, or other reason)? Yes ☐ No ☐

10. If yes to #9 above, how much weight have they lost in the past 3 months? (please enter numbers): lbs ☐ **/OR** stones ☐ lbs ☐ **/OR** kg ☐ **OR** No weight loss over past 3 months ☐

11. Have others (for example, doctors, family members) been concerned about your child's weight loss, or been concerned that they are having difficulty gaining enough weight to grow, or having difficulty maintaining their weight due to their eating habits? Yes ☐ No ☐

12. Have others (for example, doctors, family members) been concerned that your child is not growing taller as they should due to their eating habits? Yes ☐ No ☐ My child has finished growing ☐

13. Have you ever been told by **any health professional** that due to their eating habits your child is not growing as expected, or that their height was less than it should be? Yes ☐ No ☐

14. Over the past month, has **any health professional** said that your child has a nutritional deficiency due to their eating habits (for example, low iron, low vitamin B12, low vitamin C)? Yes ☐ No ☐

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15. Over the past month, has **a healthcare professional prescribed** special supplements (for example, pills, capsules, powders, or drinks containing vitamins and/or minerals and other micronutrients) **specifically to help with your child's nutrition?** Yes ☐ No ☐

16. If yes to #15 above, what has been prescribed and how much does your child take each day?

_____

17. Over the past month, has **a healthcare professional prescribed** special supplements (for example, high-calorie drinks or 'shots', or dessert-style high-calorie supplements) **specifically to help your child maintain or gain weight?** Yes ☐ No ☐

18. If yes to #17 above, what has been prescribed and how much does your child take each day?

_____

19. Is your child currently receiving any tube feeding (receiving food or fluid via a tube in their nose or into their stomach)? Yes ☐ No ☐

20. If yes to #19 above, what is the name of the **food or fluid product taken via the tube** and how much does your child take each day?

_____

21. Does your child's eating cause them difficulties in daily functioning - that is, in how they are able to go about things each day? This might be at school/college/work or when at home. Yes ☐ No ☐

22. Does your child's eating cause them difficulties in interactions with other people (for example, disagreements or arguments with parents, siblings, significant others), or difficulty making or sustaining friendships or other close relationships?
Please circle a number on the line below how difficult **interactions with other people** are for your child because of their eating, ranging from 0 (= no difficulty) to 6 (= extremely difficult)

0 1 2 3 4 5 6

23. Does your child's eating cause them difficulties in social situations, for example does it make it difficult for them to go out with friends, eat at school/college, or stay away from home?

Please circle a number on the line below how difficult **social situations** are for your child because of their eating, ranging from 0 (= no difficulty) to 6 (= extreme /tries to avoid all social situations)

0 1 2 3 4 5 6

24. Over the past month, has your child been particularly sensitive to variation in taste (for example, noticing slight differences in the taste of foods), which has put them off eating any foods or trying any new foods?

Please circle a number on the line below how much **sensitivity to taste** has affected your child's eating, ranging from 0 (= no negative effect/no particular sensitivity to taste) to 6 (= extremely negative effect, for example, leading to refusal to eat many foods, sticking only to a limited number of preferred foods, or extreme caution when eating)

0 1 2 3 4 5 6

25. Over the past month has your child been particularly sensitive to the texture or consistency of food, which has put them off eating any foods or trying any new foods (for example, does your child stick to foods of a certain texture only or have they had difficulty eating foods that have different textures mixed together such as pasta with sauce or sandwiches)?

Please circle a number on the line below how much **sensitivity to texture or consistency** has affected your child's eating, ranging from 0 (= no negative effect/no particular sensitivity) to 6 (=extremely negative effect, for example, leading to refusal to eat many foods, sticking only to a limited number of preferred foods, or extreme caution when eating)

0 1 2 3 4 5 6

26. Over the past month, has your child been particularly sensitive to the appearance of food, which has put them off eating any foods or trying any new foods (for example, if food does not look "right", such as burnt ends of chips/fries, broken biscuits/cookies, or being the "wrong" colour)?

Please circle a number on the line below how much **sensitivity to the appearance of food** has affected your child's eating, ranging from 0 (= no negative effect/no particular sensitivity) to 6 (=extremely negative effect, for example, leading to refusal to eat many foods, sticking only to a limited number of preferred foods, or extreme caution when eating)

0 1 2 3 4 5 6

27. Over the past month, how often has your child forgotten to eat or found it difficult to make time to eat?

Please circle a number on the line below how often your child has **forgotten to eat or found it difficult to make time to eat**, ranging from 0 (= never) to 6 (=always)

0 1 2 3 4 5 6

28. Over the past month, how often has your child appeared to lack enjoyment in food or eating (even if only certain foods)?

Please circle a number on the line below how often your child has **lacked enjoyment in food or eating**, ranging from 0 (= never) to 6 (=always)

0 1 2 3 4 5 6

29. Over the past month, how often has your child said or indicated they are full before their meal is finished, or stopped eating sooner than others because they had had enough?

Please circle a number on the line below how often your child has **indicated they are full or stopped eating early**, ranging from 0 (= never) to 6 (=always)

0 1 2 3 4 5 6

30. Over the past month has your child been avoiding or restricting the amount or type of food they eat, because they have said or indicated they were afraid that something bad might happen, like being sick, choking, having an allergic reaction, or being in pain?

Please circle a number on the line below how often being **afraid something bad might happen** has affected your child's eating, ranging from 0 (= never) to 6 (=always)

0 1 2 3 4 5 6

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31. Over the past month has your child avoided eating situations because they said or indicated they were worried something bad might happen, like being sick, choking, having an allergic reaction, or being in pain while eating (for example, because they might be served something they usually avoid for these reasons, or because they have had a bad experience in the past)?

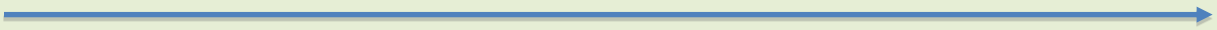
Please circle a number on the line below how often your child has **avoided eating situations** due to such worries, ranging from 0 (= never) to 6 (=always)

0 1 2 3 4 5 6

32. Over the past month has your child expressed any physical feelings of panic or anxiety (examples might include a racing heart, sweaty palms, feeling sick) when they have seen something that has made them think something bad might happen, like being sick, choking, having an allergic reaction, or being in pain while eating

Please circle a number on the line below how often your child had **had physical feelings of panic or anxiety** due to such thoughts, ranging from 0 (= never) to 6 (=always)

0 1 2 3 4 5 6



THANK YOU!