Appendix 1.

Questionnaire: The following questions were asked during the phone interview.

1. What is the current age of your child? _____
2. What age was he/she diagnosed with celiac disease? _____
3. At what age did the onset of symptoms for celiac disease begin? _____
4. What were the most prominent symptoms? _____

Diarrhea Vomiting Irritable Bowel Abdominal Pain Stomach Aches Failure to thrive weight loss Short stature Chronic fatigue Joint pain Other_____

5. Is your child on a gluten free diet now? Y/N
6. How long has he/she been on the diet? _____
7. How strictly has your child adhered to or followed the diet? Loosely/moderately/strictly Please describe _____
8. Family History
    a. Has anyone else in the (immediate) family been diagnosed with celiac disease? Y/N
    b. Does the father, mother, or any siblings have headaches? Y/N
        i. Who?_____
        ii. Please Describe (use questions 11a-c when headache_____
        iii. Does the relative still have headaches now or did they only take place during childhood? (Childhood only / Both childhood and present)
9. Past Medical History
    a. Has your child been diagnosed with a learning disorder (LD)? Y/N attention deficit disorder (ADD)? Y/N
    b. Has your child had problems with balance (ataxia)? Y/N
        i. Felt tingling (neuropathy)? Y/N?
        ii. Or weakness? Y/N

c. Does your child have seizures currently? Y/N
    i. In the past? Y/N
    ii. With fever? Y/N

d. Has your child been diagnosed with cerebral palsy or developmental disorder? Y/N

e. Has your child been diagnosed with autism or any other severe behavioral problem? Y/N
    Specify (if known) _____

10. Academics
    a. How are your child's grades in the past year? A-B/ B-C/ C-D / D-below
    b. In the past year, how many days has your child missed school?
        i. 0-5/5-10/10-15/ >15
    c. What were the causes of the missed school? _____

11. Headache
    a. Please describe your headaches
        i. Daily/episodic
        ii. Loss of appetite? Y/N
        iii. Nausea/vomiting?
        iv. Does your child want the lights off? Y/N
        v. Does the child tolerate loud noises when this headache occurs? Y/N
        vi. Does your child have a pale complexion when getting this headache? Y/N
        vii. Does your child like to lie down during a headache? Y/N
        viii. Are there any other symptoms? _____
    b. Date of Onset? _____
    c. Frequency? _____
    d. Is your child on preventative medicine for those headaches? Y/N
        i. If yes, what is the name of the medication? _____
    e. Is your child taking over the counter medicine for those headaches? Y/N
        i. If Y, is he/she taking it 2 times or less per week or 3 times or more?
    f. Has your child had an MRI or CT scan of the head?
        i. Results? _____ Abnormal/Normal
        ii. If the results were abnormal, can you have the MRI or CT scan sent to us?
    g. Are the headaches still occurring? _____ Y/N

12. Have the headaches gotten better, worse, or the same after the gluten free diet? If so, were they better by frequency, intensity, or both?