

Supplementary Table S1

Non-IgE mediated Symptom Monitoring Questionnaire before and after the Elimination Diet

Symptoms: please indicate which symptoms your child experiences?								
	Please indicate the severity of the symptoms:						What age did it start:	Score at follow up:
	none	mild		moderate		severe		
Diarrhoea: (loose, watery, frequent stools)	0	1	2	3	4	5		
Constipation: (excessive straining, low frequency, hard stools)	0	1	2	3	4	5		
Vomiting: (unexplained vomiting, often associated with abdominal pain)	0	1	2	3	4	5		
Rectal bleeding: (bleeding from the bottom when passing a stool, fresh blood)	0	1	2	3	4	5		
Abdominal pain: (affects daily functioning such as school and sleep)	0	1	2	3	4	5		
Wind/flatul: (excessive burping and painful wind)	0	1	2	3	4	5		
Bloating: (bloated/extended stomach that is hard when pressed)	0	1	2	3	4	5		
Screaming/back arching: (screaming associated with back arching and kicking legs out straight)	0	1	2	3	4	5		
Food aversion: (pushes away food, gags, holds food in mouth, spits/throws food, cries during meals)	0	1	2	3	4	5		