Appendix 1

Complementary and Alternative Medicine (CAM) Use Questionnaires.

1.Child gender (M/F): ---------- 2. Age: (date/month):----------

3.Nationality(country/region) : a) Country:-------- b)Region:----------

4.Pre-existing disease: a)No b) Yes, (If yes, please specify the disease):----------

5.Is the child on any prescribed medications? a) Yes b) No

6.Questionnaire answered by (state relation e.g. Father, Mother, other carer):

7.Has your child undergone any CAM in the recent 12 months?

(please include any supplementation, therapy or practices done other than prescribed medication or treatment, e.g. over-the-counter medicines, vitamins/minerals, cauterization "Wassem", Honey with black seed, mercury, lead, herbs)

-Yes -No

8.What kind of CAM is your child using? please specify (use back of questionnaire for further CAM3, CAM4, etc).

CAM1----------

CAM2----------

Please tick as appropriate from 8-11 for each CAM as direct response of the patient or direct guardian. (Use back of questionnaire for further CAM3, CAM4 etc…)

CAM1:

9. Reason for CAM use

1.Treatment/symptom relief

2. Prevention of disease/symptoms

3. Health promotion

4. Nutritional benefit

5.Others (state: ----------)

10. Effect of CAM use

1. Excellent

2.Good

3. Fair

4. Poor

5. Very poor

10. Satisfaction after CAM use

1. Completely satisfied

2. Somewhat satisfied

3. Neither satisfied nor dissatisfied

4. Somewhat dissatisfied

5. Completely dissatisfied

11. Adverse events (as described by patient/guardian)

1. No 2. Yes (If yes, please specify the nature of adverse reaction/ event: ----------)

CAM 2:

9. Reason for CAM use

1.Treatment/symptom relief

2. Prevention of disease/symptoms

3. Health promotion

4. Nutritional benefit

5.Others (state: ----------)

10. Effect of CAM use

1. Excellent

2.Good

3. Fair

4. Poor

5. Very poor

10. Satisfaction after CAM use

1. Completely satisfied

2. Somewhat satisfied

3. Neither satisfied nor dissatisfied

4. Somewhat dissatisfied

5. Completely dissatisfied

11. Adverse events (as described by patient/carer)

1. No 2. Yes (If yes, please specify the nature of adverse reaction/ event: ----------)

12. Have you previously informed your healthcare provider about your CAM use?

- Yes (Select which one: Nurse doctor pharmacist other)
- No