

ASSESSMENT FORMS

NAME

DATE

Mitochondrial Dysfunction

	Never	Occasionally	Often	Regularly
History of infections (EBV, Lyme, etc.)?	N	Y		
Dizziness upon standing up quickly	0	1	2	3
Unable to tolerate much exercise	0	1	2	3
Poor exercise or muscle stamina	0	1	2	3
Low muscle tone?	N	Y		
Brain fog	0	1	2	3
Difficulty focusing	0	1	2	3
Vision or hearing problems	0	1	2	3
General or chronic fatigue	0	1	2	3
Afternoon headaches	0	1	2	3
Migraines or seizures	0	1	2	3
Mood problems: anxiety, depression, or bipolar	0	1	2	3
Poor brain processing (cognition)	0	1	2	3
Blood sugar issues	0	1	2	3
Breathing problems	0	1	2	3
Overweight?	N	Y		
Low body temperature	N	Y		
Intolerant to heat	0	1	2	3
Low thyroid lab numbers?	N	Y		
Little or no skin sweating?	N	Y		
Suppressed immune system?	N	Y		
Catch colds or get sick easily?	N	Y		
Chronic inflammation	0	1	2	3
Cannot fall asleep	0	1	2	3
Cannot stay asleep	0	1	2	3
Slow mover in the morning (hard to get going)	0	1	2	4
Wake up tired, even after 6 or more hours of sleep	0	1	2	3
Eyes sensitive to bright or direct light	0	1	2	3
Weight gain when under stress	0	1	2	3
Loss of libido	N	Y		

Mitochondrial Dysfunction Total

GREEN	YELLOW	RED
0-16	17-45	46-107

Drainage Dysfunction Susceptibility

	Never	Occasionally	Often	Regularly
Constipation (pooping one or fewer times daily)	0	1	2	3
Feeling that bowels do not empty completely	0	1	2	3
General or chronic fatigue	0	1	2	3
Mood problems: anxiety, depression, or bipolar	0	1	2	3
Poor brain processing (cognition)	0	1	2	3
Chronic inflammation	0	1	2	3
Wake up between 1 a.m. to 4 a.m.	0	1	2	3
Edema, swelling or retain extra fluids	0	1	2	3
Skin problems, rashes, itches, hives, eczema, or acne	0	1	2	3
Yellowish skin, face	0	1	2	3
Suppressed immune system	0	1	2	3
Can't clear infections, despite following pathogen protocols	0	1	2	3
Sore or swollen breast tissue	0	1	2	3
Heart palpitations or irregular heartbeat	0	1	2	3
Light, sound, or EMF sensitivities	0	1	2	3
Morning stiffness	0	1	2	3
Brain fog	0	1	2	3
Swollen glands	0	1	2	3
Cellulite or flabby skin	0	1	2	3
Varicose or spider veins	0	1	2	3
Kidney problems	0	1	2	3
Breathing or lung issues	0	1	2	3
Skin doesn't sweat	0	1	2	3
Puffy Eyes	0	1	2	3

Drainage Dysfunction Total

GREEN	YELLOW	RED
0-14	15-35	36-72

ASSESSMENT FORMS

NAME _____

DATE

Minerals & Electrolytes

Edema (swelling) in ankles or wrists

Muscle cramping

Poor muscle endurance

Frequent urination

Frequent thirst

Crave salt

Unable to hold breath for long periods

Shallow, rapid breathing

History of carpal tunnel syndrome

History of lower right abdominal pains or ileocecal valve problems

History of stress fracture

Bone loss (reduced density on bone scan)

Crave chocolate

Feet have a strong odor

History of anemia

Whites of eyes (sclera) are blue-tinted

Hoarse voice

White spots on fingernails

Minerals & Electrolyte Total

GREEN	YELLOW	RED
0-19	20-35	36-59

Blood Sugar

Crave sweets during the day

Irritable if meals are missed

Eating relieves fatigue

Agitated, easily upset, nervous

Fatigue after meals

Must have sweets after meals

Forgetful; poor memory

Feel better or calmer after eating

Prone to infections and colds

History of diabetes in your family

Sugar (glucose) detected in urine test?

Hair loss at ankles/frictional alopecia?

Blood Sugar Total

GREEN	YELLOW	RED
0-10	11-24	25-45

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer, if there is a number. Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

NAME

DATE

Stomach

	Never	Occasionally	Often	Regularly
Belching or burping	0	1	2	3
Gas quickly following a meal	0	1	2	3
Bad breath	0	1	2	3
Feel full while eating and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Stomach pain, burning, or aching 1 to 4 hours after eating	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, or caffeine	0	1	2	3
Indigestion	0	1	2	3
Abdominal bloating	0	1	2	3
Constipation	0	1	2	3
Diminished appetite	0	1	2	3

Stomach Total

GREEN	YELLOW	RED
0-11	12-26	27-36

Small Intestine

Increased gut motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Mucus in stool	0	1	2	3
Poorly formed or loose stools	0	1	2	3
Four or more large stools daily	0	1	2	3
Stools have foul odor	0	1	2	3
Suspect nutrient malabsorption	0	1	2	3
Diagnosed with celiac disease, irritable bowel syndrome (IBS), or diverticulosis/diverticulitis	0	1	2	3
Stomach cramps	0	1	2	3
Flatulence (gas)	0	1	2	3
Fiber-rich diet doesn't help constipation	0	1	2	3
History of pimples or skin eruptions?	N	Y		
Any known food allergies?	N	Y		

Small Intestine Total

GREEN	YELLOW	RED
0-10	11-24	25-45

Colon

	Never	Occasionally	Often	Regularly
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or buildup of debris on tongue	0	1	2	3
Use laxatives	0	1	2	3
History of bladder and/or kidney infection	0	1	2	3
Yeast infection (including vaginal)	0	1	2	3
Fingernail and/or toenail fungus	0	1	2	3
Use of antibiotics in past year?	N	Y		

Colon Total

GREEN	YELLOW	RED
0-9	10-24	25-36

Intestinal Permeability

Adverse reactions to foods	0	1	3	4
Unpredictable food reactions	0	2	4	6
Aches, pains, and swelling throughout your body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Food allergies	0	2	4	5
Frequent bloating and distention after eating	0	1	2	3

Leaky Gut Total

GREEN	YELLOW	RED
0-7	8-15	16-24

NAME

DATE

Hypothyroid

	Never	Occasionally	Often	Regularly
Tired or sluggish	0	1	2	3
Feel cold (hands, feet, or your whole body)	0	1	2	3
Require an excessive amount of sleep to function properly	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression or lack of motivation	0	1	2	3
Thinning of outer third of eyebrows	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dry skin and/or scalp	0	1	2	3
Slow brain processing	0	1	2	3
Lack of or diminished sex drive	0	1	2	3
Infertility or impotency		N	Y	
Heavy or profuse menstrual bleeding (women only)	0	1	2	3

Hypothyroid Total

GREEN	YELLOW	RED
0-11	12-22	23-40

Hyperthyroid

	Never	Occasionally	Often	Regularly
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse, even at rest	0	1	2	3
Nervous or emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Eyes appear bulging or swollen	0	1	2	3
Difficulty gaining weight	0	1	2	3

Hyperthyroid Total

GREEN	YELLOW	RED
0-5	6-10	11-24

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

Pathogens

NAME

DATE

Parasites

	Never	Occasionally	Often	Regularly		Never	Occasionally	Often	Regularly
Restless sleep (toss, turn, or wake up often)	0	1	2	3	Travel in developing nations	0	2	4	6
Skin issues, rashes, itches, hives, eczema, or acne	0	2	4	6	Eat pork products	0	1	2	3
Frequent diarrhea or loose stools	0	1	2	3	Eat sushi, raw fish	0	2	4	6
Alternating constipation and diarrhea	0	1	2	3	Sleep with pets on bed	0	1	2	3
SIBO (small intestinal bacterial overgrowth), feel bloated or gassy	0	1	2	3	Bed-wetting	0	1	2	3
Bowel urgency, occasional accidents	0	1	2	3	Frequent vomiting	0	1	2	3
Abdominal pains, cramps, or burning	0	1	2	3	Loss of appetite	0	1	2	6
Rectal, anal itch	0	2	4	6	Hungry all the time, bottomless pit, hungry after meals	0	2	4	6
Anal fissures (small, painful tears or cracks)	0	2	4	6	Strong sugar and processed food cravings	0	1	2	3
Stomach or small intestinal ulcers or lesions	0	1	2	3	Breathing problems, asthma	0	2	4	6
Grinding of teeth when asleep	0	2	4	6	Pain in belly button area (umbilicus)	0	1	2	4
Picking at nose, boring nose with finger	0	2	4	6	Blurry, unclear vision	0	1	2	3
Excess boogers in nose and scab-like boogers	0	2	4	6	Eye floaters	0	2	4	6
Fingernail biting	0	1	2	3	Lethargy, apathy (disinterest)	0	1	2	3
Headaches/Migraines	0	2	4	6	Menstrual problems	0	1	2	3
Irritable (no apparent reason)	0	1	2	3	Dry lips	0	1	2	3
Mood disorder, depression, anxiety, or suicidal thoughts	0	1	2	3	Drooling while asleep	0	1	2	3
Hyperactive tendency (nervous)	0	1	2	3	Occult blood in stool (from lab test)	0	1	2	3
Dark circles under eyes	0	2	4	6	Swim in creeks, rivers, lakes	0	2	4	6
Need for extra sleep, wake unrefreshed	0	1	2	3	History of <i>Giardia</i> , pinworms, or other parasites?	N	Y		
Allergies and/or food sensitivities	0	2	3	4	Do you work in childcare?	N	Y		
Fevers of unknown origin	0	1	2	3	History of or currently have cancer?	N	Y		
Night sweats (not menopausal)	0	1	2	3					
Kiss pets, allow pets to lick your face	0	1	2	4					
Increase of symptoms around a full moon	0	2	6	8					
Anemia (low iron/hemoglobin on blood test)	0	1	2	4					
Iron deficiency	0	2	4	6					
Vitamin B6 deficiency	0	2	4	6					
Zinc deficiency and/or white spots on nails	0	2	4	6					
Frequent colds, flu, sore throats	0	1	2	3					

Parasite Infection Total

GREEN	YELLOW	RED
0-46	47-96	97-242

NAME

DATE

SIBO (Small Intestinal Bacterial Overgrowth)

Abdominal distention after consuming fiber, starches, or sugar

Abdominal distention after taking certain probiotics or other dietary supplements

Abdominal distention, bloating, or a noisy gut after eating healthy vegetables

Bloating or feeling full in upper abdominal area (just below rib cage)

SIBO Total

Never

Occasionally

Often

Regularly

0

1

2

3

GREEN

YELLOW

RED

0-1

2-4

5-12

Lyme Disease Risks

Ever diagnosed with Lyme disease?

Dry sockets or infected tooth extractions

Ever bitten by a tick?

Ever had a bullseye rash on any part of your body?

Mother ever diagnosed with Lyme disease?

Spouse/partner/significant other diagnosed with Lyme disease?

Ever diagnosed with chronic fatigue syndrome, fibromyalgia, lupus, rheumatoid arthritis (RA), multiple sclerosis (MS), or an autoimmune condition?

Ever diagnosed with Parkinson's disease, Alzheimer's disease, or Tourette's syndrome?

Frequently go camping, hunting, or engage in outdoor activities?

History of a heart murmur or valve prolapse?

Lyme Disease Risks Total

Never

Occasionally

Often

Regularly

N

Y

0

1

2

3

N

Y

N

Y

N

Y

N

Y

N

Y

GREEN

YELLOW

RED

0-9

10-18

19-59

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NAME					DATE				
	Never	Occasionally	Often	Regularly		Never	Occasionally	Often	Regularly
Lyme									
Arthritis-like joint pain or swelling	0	2	4	6	Woozy (mentally unclear or hazy)	0	2	4	6
Pain migrates or moves around to different areas of your body	0	2	4	6	Tremors	0	2	4	6
Forgetfulness or poor short-term memory	0	2	4	6	Headaches	0	1	2	3
Confusion, difficulty thinking	0	1	2	3	Impulsivity, aggression, or bipolar	0	1	2	3
Disorientation (getting lost; going to wrong places)	0	1	2	3	Depression	0	1	2	3
Difficulty with speech or writing	0	4	6	8	Hallucinations, paranoia, or schizophrenia	0	2	4	6
Tingling, numbness, burning, or stabbing sensations	0	4	6	8	Panic attacks	0	1	2	3
Disturbed sleep: too much, too little, early awakening	0	2	4	6	Eating disorder	0	4	6	8
Unexplained fevers, sweats, chills, or flushing	0	1	2	3	Pulse skips	0	4	6	8
Unexplained weight change (loss or gain)	0	1	2	3	Skin hypersensitivity	0	2	4	6
Difficulty swallowing	0	1	2	3	Gastrointestinal problems	0	4	6	8
Fatigue, lack of energy	0	1	2	3	Change in bowel function	0	4	6	8
Sore throat or swollen glands	0	1	2	3					
Pelvic or testicular pain	0	4	6	8					
Crepitus (joint cracking)	0	4	6	8					
Stiff neck	0	2	4	6					
Twitching of facial or other muscles	0	1	2	3					
Muscle pain or cramps	0	1	2	3					
Costochondritis (sternum/breastbone and rib junction pain)	0	4	6	8					
Right shoulder pain (AC joint)	0	1	2	3					
Facial paralysis (Bell's palsy)	0	4	6	8					
Unexplained menstrual irregularity	0	4	6	8					
Unexplained breast milk production	0	4	6	8					
Irritable bladder or bladder dysfunction	0	4	6	8					
Sexual dysfunction or low libido	0	4	6	8					
Blurry or double vision	0	1	2	3					
Ear buzzing, ringing, or pain	0	1	2	3					
Vertigo or increased motion sickness	0	4	6	8					
Light-headedness, poor balance, difficulty walking	0	4	6	8					

Lyme Disease Current Symptoms Total

GREEN	YELLOW	RED
0-31	32-95	96-230

Pathogens

NAME					DATE				
	Never	Occasionally	Often	Regularly		Never	Occasionally	Often	Regularly
Babesia									
Abdominal pain	0	2	4	6	Enlarged spleen	0	1	2	3
Shortness of breath	0	1	2	3	Heart palpitations, pulse skips, Tachycardia	0	4	6	8
Air hunger (episodes of breathlessness)	0	4	8	10	Dark urine with or without blood	0	4	6	8
Anemia (low iron/hemoglobin on blood test)	0	1	2	3	Weakness	0	1	2	3
Low back stiffness or pain	0	1	2	3	Weight loss	0	1	2	3
Low blood sugar	0	2	4	6	Elevated sedimentation (sed) rate on lab test	0	1	2	3
Cough	0	1	2	3	Dizziness	0	1	2	3
Disturbed sleep: frequent waking	0	4	6	8	Light headedness	0	1	2	3
Excessive sleepiness	0	1	2	3	Babesia Total				
Encephalopathy (brain malfunction, brain issues)	0	1	2	3					
Fatigue, tiredness, poor stamina	0	1	2	3					
Fevers	0	1	2	3					
Headaches	0	4	6	8					
Hemolysis (destruction of red blood cells)	0	2	4	6					
Enlarged liver	0	2	4	6					
Imbalance	0	2	4	6					
Generalized ill feeling	0	1	2	3					
Muscle pains or cramps	0	1	2	3					
Nausea, vomiting	0	2	4	6					
Neck stiffness, pain	0	1	2	3					
Night sweats	0	1	2	3					
Poor appetite	0	2	4	6					
Shaking chills	0	4	6	8					

GREEN	YELLOW	RED
0-29	30-60	61-146

Pathogens

NAME

DATE

Bartonella

	Never	Occasionally	Often	Regularly
Abdominal pain	0	2	4	6
Anemia (low iron/hemoglobin on blood test)	0	1	2	3
Anxiety	0	2	4	6
Back stiffness	0	1	2	3
Chills	0	1	2	3
Disturbed sleep: too much, too little, fractionated, early awakening	0	1	2	3
Ear buzzing, ringing, pain, sound sensitivity	0	2	4	6
Brain dysfunction	0	1	2	3
Hemolysis (destruction of red blood cells)	0	2	4	6
Endocarditis	0	2	4	6
Myocarditis	0	2	4	6
Fatigue, tiredness, poor stamina	0	1	2	3
Low-grade fever	0	2	4	6
Headaches	0	1	2	3
Enlarged liver	0	2	4	6
Immune deficiency	0	2	4	6
Feeling of coming down with the flu	0	2	4	6
Insomnia	0	1	2	3
Jaundice (yellowing of skin)	0	4	6	8
Joint pain or swelling	0	1	2	3
Lymph nodes swollen	0	4	6	8
Generalized ill feeling	0	1	2	3
Muscle pains or cramps, especially in calves	0	4	6	8
Foot pain or plantar fasciitis-type pain (heels or soles of the feet)	0	4	6	8
Stretch mark-like rash (not from overweight)	0	6	8	12
Maculopapular rash (small red bumps)	0	4	6	8
Spider veins	0	2	4	6
Seizures	0	4	6	8
Sleepiness or drowsiness	0	2	4	6

	Never	Occasionally	Often	Regularly
Sore throat	0	2	4	6
Enlarged spleen	0	2	4	6
Shinbone pain	0	4	6	8
Tremors	0	2	4	6
Twitching of facial muscles	0	2	4	6
Weight loss	0	1	2	3
Eyes: blurred vision, red eyes, dry eyes, depth perception issue, light sensitivity	0	2	4	6
Anxiety, panic attacks, or excessive worry	0	2	4	6
Obsessive-compulsive disorder (OCD)	0	4	6	8

Bartonella Total

GREEN	YELLOW	RED
0-29	30-79	80-217

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer, if there is a number. Total your score in the space provided for each section. Compare your results with the rating system for each section. A score in the yellow or red range suggests this area is more likely a problem for you.

Toxicants & Toxins

General Toxicity

	Never	Occasionally	Often	Regularly
Live on or near a golf course?	N	Y		
Live near a freeway or high-tension wires?	N	Y		
Wear conventional sunscreen?	N	Y		
Wear perfume or cologne?	N	Y		
Use air fresheners in your house, car, or workplace?	N	Y		
Were you the first-born child?	N	Y		
Receive static shocks (doorknob, car, light switch, other people, etc.)	0	1	2	3
Headaches or migraines	0	1	2	3
Word reversal or trouble finding words	0	1	2	3
Sensitivity to skin or touch	0	1	2	3
Poor short-term memory	0	1	2	3
Chronic sinus issues or congestion	0	1	2	3
Difficulty losing weight regardless of diet or exercise	0	1	2	3
Excessive perspiring during day or night	0	1	2	3
Cold extremities (hands and feet)	0	1	2	3
Issues processing new information	0	1	2	3
Chronic fungal or viral infection, including <i>Candida</i> , foot fungus, warts, or jock itch	0	1	2	3
Get sick often	0	1	2	3
Weakness or numbness in extremities	0	1	2	3
Joint pain	0	1	2	3
Muscle cramps, aches, sharp pains	0	1	2	3
Muscle twitching	0	1	2	3
Stomach pain	0	1	2	3
Appetite swings	0	1	2	3
Rashes or rosacea	0	1	2	3

General Toxicity Total

GREEN	YELLOW	RED
0-19	20-50	51-81

Radioactive Elements

	Never	Occasionally	Often	Regularly
History of or currently have cancer?	N	Y		
Suppressed immune system?	N	Y		
Osteoporosis or osteopenia diagnosis?	N	Y		
Can't clear infections, despite following pathogen protocols?	N	Y		
Chronic <i>Candida</i> infection	0	2	4	6
Fatigue	0	2	4	6
Anemia	0	2	4	6
Skin (red, dry, itchy, color changes)	0	1	2	3
Hair loss	0	2	4	6
Loss of appetite	0	1	2	3
Nausea and vomiting	0	1	2	3
Low blood cell count	0	1	2	3
Seizures	0	1	2	3
Earaches or difficulty hearing	0	1	2	3
Hormone problems	0	1	2	3
Sore or dry mouth	0	1	2	3
Taste changes	0	1	2	3
Difficulty swallowing	0	2	4	6
Voice changes, hoarseness	0	1	2	3
Dry eyes	0	1	2	3
Stiff jaw	0	1	2	3
Tooth decay	0	1	2	3
Soreness or swelling of the breast	0	1	2	3
Heart palpitations	0	2	4	6
Irregular heartbeat	0	1	2	3
Stomach ulcers	0	2	4	6
Kidney problems	0	1	2	3
Bladder infection (cystitis)	0	2	4	6
Burning or pain during urination	0	1	2	3
Loss of bladder control	0	1	2	3
Fertility problems	0	1	2	3
Sexual problems (male & female)	0	1	2	3

Radioactive Elements Total

GREEN	YELLOW	RED
0-16	17-40	41-146

Lead Toxicity

	Never	Occasionally	Often	Regularly
Have lived in a home built before 1978 using lead-based paint	0	2	4	6
Do home renovation, including sandblasting or moving walls	0	2	4	6
Currently live or previously lived in a mining community or area	0	2	4	6
Involved in construction, soldering, metal salvage, or stained glass	0	2	4	6
Are an electrician, handle electrical devices, electrical wiring, ballasts, or TV glass	0	2	4	6
Paint or handle/make ceramics, brass, bronze, or crystal	0	2	4	6
Handle and/or reload ammunition	0	2	4	6
Read the newspaper regularly before 1985	0	2	4	6
Previously or currently consume a coral calcium supplement	0	2	4	6
Wear lipstick	0	2	4	6
Previously wore or currently wear eye cosmetics containing kohl (a dark pigment that's not FDA-approved for makeup)	0	2	4	6
Are around or have a lot of fake leather or vinyl	0	2	4	6
Get your hair colored	0	2	4	6
Get stomachaches in the morning	0	1	2	3
Eyelid swelling	0	1	2	3
Eyelid twitching	0	1	2	3
Chest or heart pain	0	1	2	3
Metallic taste in mouth	0	1	2	3
Teeth sensitivity	0	1	2	3
Bleeding gums	0	1	2	3
High blood pressure	0	1	2	3
Inability to decide/indecisiveness	0	1	2	3
Overwhelmed or fearful feeling	0	1	2	3
Anemia (low iron/hemoglobin on blood test)	0	1	2	3
Peeling of top layer of skin (hands, feet)	0	1	2	3
Dry skin	0	1	2	3
Depression	0	1	2	3
Dyslexia or loss of your place while reading, even as a child	0	1	2	3
Gout (arthritic pain, especially in big toes)	0	1	2	3

Lead Toxicity Total

GREEN	YELLOW	RED
0-37	38-65	66-126

Toxicants & Toxins

NAME					DATE				
	Never	Occasionally	Often	Regularly		Never	Occasionally	Often	Regularly
Mycotoxins									
See mold growing at home, work, or school?	N	Y			Wake up during the night with an attack of coughing	0	1	2	3
Ever experienced water damage at home, work, or school?	N	Y			Chest tightness when around animals or a dusty part of the house	0	1	2	3
Home, workplace, or school has a damp or mildewy odor	0	1	2	3	Achy all over	0	1	2	3
Spending time in basement causes or worsens symptoms	0	4	6	8	Headaches	0	1	2	3
Basement ever wet?	N	Y			Extreme or unusual fatigue	0	1	2	3
Symptoms decrease when spend time in a different location for at least a few days?	N	Y			Hoarse voice	0	1	2	3
Plumbing in your kitchen or bathroom leaks or has leaked in the past?	N	Y			Memory loss	0	1	2	3
Wet spots anywhere in your home (whether currently or past)?	N	Y			Difficulty recalling names of people you know	0	1	2	3
Often see condensation (fog) on the inside of windows and/or cold surfaces in your home?	N	Y			Sensitive to chemicals and smells	0	1	2	3
Car has a mildewy smell?	N	Y			Sensitive to EMF's	0	1	2	3
Brain fog	0	1	2	3	Bloating or SIBO	0	1	2	3
Reactions to supplements opposite of expected	0	1	2	3	Blurry vision	0	1	2	3
Nosebleeds	0	1	2	3	Difficulty sleeping or insomnia	0	1	2	3
Body rashes	0	1	2	3	Anxiety or depression	0	1	2	3
Any skin conditions?	N	Y			Frequent urination, unable to hold bladder	0	1	2	3
Anyone in your home have asthma-like symptoms?	N	Y							
Sinus infections	0	1	2	3					
One or more family members have chronic sinus infections or irritations	0	1	2	3					
Runny, blocked, or stuffy nose	0	1	2	3					
Experience static shocks	0	1	2	3					
Wheezing or whistling in your chest	0	1	2	3					
Wake up in the morning with a feeling of tightness in your chest	0	1	2	3					
Wake up during the night with shortness of breath	0	1	2	3					
Shortness of breath when you're not doing anything strenuous	0	1	2	3					

Mold Total _____

GREEN	YELLOW	RED
0-19	20-68	69-138

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer, if there is a number. Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.