

# Back In Action Chiropractic

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## Candida Questionnaire

NAME \_\_\_\_\_ DATE \_\_\_\_\_

### Section A: History

Circle the point score in the right-hand column if your answer is "yes" to the corresponding question.

1. Have you ever taken tetracyclines or other antibiotics for one month or longer?.....35
  2. Have you, at any time in your life, taken "broad spectrum" antibiotics for respiratory, urinary, or other infections? (For 2 months or longer, or in shorter courses 4 or more times in a 1-year period.).....35
  3. Have you taken a broad spectrum antibiotic drug – even a single course?.....6
  4. Have you, at any time in your life, been bothered by persistent prostaticitis, vaginitis, or other problems affecting your reproductive organs?.....25
  5. Have you been pregnant:  
    2 or more times?.....5  
    1 time?.....3
  6. Have you taken birth control pills:  
    for more than 2 years?.....15  
    For 6 months to two years?.....8
  7. Have you taken prednisone, Decadron, or other cortisone-type drugs:  
    for more than 2 weeks?.....15  
    for less than 2 weeks?.....6
  8. Does exposure to perfumes, insecticides, fabric shop odors, or other chemicals provoke:  
    moderate to severe symptoms?.....20  
    mild symptoms?.....5
  9. Are your symptoms worse on damp, muggy days or in moldy places?.....20
  10. Have you ever had athlete's foot, ringworm, "jock itch," or other chronic fungus of the skin or nails that you would consider:  
    severe or persistent?.....20  
    mild to moderate?.....10
  11. Do you crave sugar?.....10
  12. Do you crave breads?.....10
  13. Do you crave alcoholic beverages?.....10
  14. Does tobacco smoke really bother you?.....10
- Total Score, Section A.....\_\_\_\_\_

**Section B: Major Symptoms**

For each of your symptoms, enter the appropriate figure in the "Point Score" column:

- Symptom is occasional or mild.....3 points
- Symptom is frequent or moderately severe.....6 points
- Symptom is severe and/or disabling.....9 points

1. Fatigue or lethargy.....
2. Feeling of being "drained".....
3. Poor memory.....
4. Feeling "spacy" or "unreal".....
5. Inability to make decisions.....
6. Numbness, burning, or tingling.....
7. Insomnia.....
8. Muscle aches.....
9. Muscle weakness or paralysis.....
10. Pain and/or swelling in joints.....
11. Abdominal pain.....
12. Constipation.....
13. Diarrhea.....
14. Bloating, belching, or intestinal gas.....
15. Troublesome vaginal burning, itching, or discharge.....
16. Prostatitis.....
17. Impotence.....
18. Loss of sexual desire or feeling.....
19. Endometriosis or infertility.....
20. Cramps and/or other menstrual irregularities.....
21. Premenstrual tension.....
22. Attacks of anxiety or crying.....
23. Cold hands or feet and/or chilliness.....
24. Shaking or irritable when hungry.....
- Total Score, Section B.....

**Section C: Other Symptoms**

For each of your symptoms, enter the appropriate figure in the "Point Score" column:

- Symptom is occasional or mild.....1 point
- Symptom is frequent or moderately severe.....2 points
- Symptom is severe and/or disabling.....3 points

- 1. Drowsiness.....
- 2. Irritability or jitteriness.....
- 3. Lack of coordination.....
- 4. Inability to concentrate.....
- 5. Frequent mood swings.....
- 6. Headache.....
- 7. Dizziness/loss of balance.....
- 8. Pressure above ears, feeling of head swelling.....
- 9. Tendency to bruise easily.....
- 10. Chronic rashes or itching.....
- 11. Numbness or tingling.....
- 12. Indigestion or heartburn.....
- 13. Food sensitivity or intolerance.....
- 14. Mucus in stool.....
- 15. Rectal itching.....
- 16. Dry mouth or throat.....
- 17. Rash or blisters in mouth.....
- 18. Bad breath.....
- 19. Foot, hair, or body odor not relieved by washing.....
- 20. Nasal congestion or post nasal drip.....
- 21. Nasal itching.....
- 22. Sore throat.....
- 23. Laryngitis.....
- 24. Cough or recurrent bronchitis.....
- 25. Pain or tightness in chest.....
- 26. Wheezing or shortness of breath.....
- 27. Urinary frequency or urgency.....
- 28. Burning during urination.....
- 29. Spots in front of eyes or erratic vision.....
- 30. Burning or tearing of eyes.....
- 31. Recurrent infections or fluid in ears.....
- 32. Ear pain or deafness.....
- Total Score, Section C.....

**Summary Section**

Total Score, Section A (carry forward from above)..... \_\_\_\_\_

Total Score, Section B (carry forward from above)..... \_\_\_\_\_

Total Score, Section C (carry forward from above)..... \_\_\_\_\_

Grand total score..... \_\_\_\_\_

The grand total score will help you and your physician to decide if your health problems may be yeast-connected. Scores in women will run higher, as 7 items in the questionnaire apply exclusively to women, while only 2 apply exclusively to men.

<b>Likelihood of yeast-related health problems</b>	<b>Women's Score</b>	<b>Men's Score</b>
Almost certainly present	180+	140+
Probably present	120-180	90-140
Possibly present	60-120	40-90
Not likely present	0-60	0-40

This questionnaire was adapted from William Crook's "The Yeast Connection."