

Crista Mold Questionnaire

Date
Taken

CHECK **ALL SYMPTOMS** EXPERIENCED IN THE **PAST 3-6 MONTHS**

CATEGORY 1

- | | | |
|--|---|--|
| <input type="checkbox"/> Brain fog | <input type="checkbox"/> Feeling overwhelmed | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Feel tired all the time | <input type="checkbox"/> Episodic/chronic dry cough | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Frequent runny nose | <input type="checkbox"/> Irritated lungs | <input type="checkbox"/> Delayed recovery from colds |
| <input type="checkbox"/> Blow your nose often | <input type="checkbox"/> Blood-streaked mucous | <input type="checkbox"/> Exhausted from exercise |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Nasal polyps | <input type="checkbox"/> Frequent static shocks |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Coated tongue | <input type="checkbox"/> Increased thirst |
| <input type="checkbox"/> Post-nasal drip | <input type="checkbox"/> Sores in the mouth | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Bumps on back of throat | <input type="checkbox"/> Feeling of internal vibration |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Thrush | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sore or itchy ear canals | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Frequent yawning or sighing | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Drunken feeling |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Bothered by loud noises | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Skin rash | <input type="checkbox"/> Yeast infection |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Burning or itchy skin | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Eye irritation | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Intestinal gas |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Spider veins | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Frequent change in vision | <input type="checkbox"/> Bothered by tags and seams on clothing | <input type="checkbox"/> Feeling bloated |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Protruding veins on limbs | <input type="checkbox"/> Crave sweets |
| <input type="checkbox"/> Sensitivity to sunlight | <input type="checkbox"/> Lower extremity edema | <input type="checkbox"/> Crave alcohol |
| <input type="checkbox"/> Nervousness/can't settle | <input type="checkbox"/> Clear your throat often | |
| <input type="checkbox"/> Low mood or depressed | | |

TOTAL **CATEGORY 1** BOXES MARKED: _____

- 0-4 boxes marked = Score 0
- 5-9 boxes marked = Score 1
- 10-15 boxes marked = Score 2
- 16+ boxes marked = Score 3

CATEGORY 1 SCORE _____

CATEGORY 2

- | | | |
|---|---|--|
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Food sensitivities | <input type="checkbox"/> Non-obstructive sleep apnea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chemical sensitivities | <input type="checkbox"/> Difficulty thinking clearly |
| <input type="checkbox"/> Burning lungs | <input type="checkbox"/> Abnormal reaction to antibiotics | <input type="checkbox"/> Disorientation |
| <input type="checkbox"/> Recurrent respiratory infections | <input type="checkbox"/> Epstein-Barr virus | <input type="checkbox"/> Balance Issues |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Recurrent yeast infections | <input type="checkbox"/> Slow reflexes |
| <input type="checkbox"/> Allergies aren't well controlled by medication | <input type="checkbox"/> Bacterial vaginosis | <input type="checkbox"/> Incoordination |
| <input type="checkbox"/> Voice sounds nasally | <input type="checkbox"/> Recurrent athlete's foot, jock itch, or toenail fungus | <input type="checkbox"/> Numbness or tingling |
| <input type="checkbox"/> Plugged or clogged ears | <input type="checkbox"/> Peeling/sloughing skin | <input type="checkbox"/> Nerve pains |
| <input type="checkbox"/> Chronic sinusitis | <input type="checkbox"/> Episodes of fast heart rate | <input type="checkbox"/> Unexplained menstrual changes |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Overactive bladder |
| <input type="checkbox"/> Alternating constipation/diarrhea | <input type="checkbox"/> Raynaud's syndrome | <input type="checkbox"/> Bladder infection |
| <input type="checkbox"/> Diarrhea | | <input type="checkbox"/> React to musty spaces |
| <input type="checkbox"/> Irritable bowel | | |

TOTAL **CATEGORY 2** BOXES MARKED: _____

- 0-2 boxes marked = Score 0
- 3-5 boxes marked = Score 1
- 6-9 boxes marked = Score 2
- 10+ boxes marked = Score 3

CATEGORY 2 SCORE _____

Continue to Category 3

Crista Mold Questionnaire continued

CHECK **ALL SYMPTOMS** EXPERIENCED IN THE **PAST 3-6 MONTHS**

CATEGORY 3

- | | | |
|--|---|---|
| <input type="checkbox"/> Daily use of sinus spray, sinus prescription, or Neti pot | <input type="checkbox"/> Asthma that's difficult to control with medication | <input type="checkbox"/> Liver pain or swelling |
| <input type="checkbox"/> Sinus surgery at any time in your life | <input type="checkbox"/> Idiopathic pneumonitis | <input type="checkbox"/> Fatty liver |
| <input type="checkbox"/> Chronic inflammatory response syndrome (CIRS) | <input type="checkbox"/> Lung scarring or nodules | <input type="checkbox"/> Non-alcoholic steatohepatitis (NASH) |
| <input type="checkbox"/> MARCoNS | <input type="checkbox"/> Respiratory distress | <input type="checkbox"/> Interstitial cystitis |
| <input type="checkbox"/> Peanut allergy | <input type="checkbox"/> Aspergillosis | <input type="checkbox"/> Kidney pain or swelling |
| <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Coagulation abnormalities | <input type="checkbox"/> Nephritis |
| <input type="checkbox"/> Dysautonomia | <input type="checkbox"/> Atriovenous abnormalities | <input type="checkbox"/> Chronic pelvic pain |
| <input type="checkbox"/> Postural Tachycardia Syndrome (PoTS) | <input type="checkbox"/> Churg Strauss Syndrome | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Histamine intolerance | <input type="checkbox"/> Hepatocellular carcinoma |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Erythema nodosum | <input type="checkbox"/> Previous or current cancer diagnosis |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Eosinophilic esophagitis | <input type="checkbox"/> Mast cell activation syndrome (MCAS) |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Exposure to water-damaged building any time in your life |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Non-celiac intestinal disease | <input type="checkbox"/> Exposure to mold |
| <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Positive Shoemaker tests |
| | <input type="checkbox"/> Cyclical vomiting syndrome | |

TOTAL **CATEGORY 3** BOXES MARKED: _____

Score 1 for each box marked
Boxes marked and score will be the same for this category

CATEGORY 3 SCORE _____

Continue to Results

TOTAL MOLD RISK RESULTS

Gather your Category scores from the 3 previous categories

CATEGORY 1 SCORE: _____ +

CATEGORY 2 SCORE: _____ +

CATEGORY 3 SCORE: _____ = **TOTAL MOLD RISK** _____

TOTAL MOLD RISK RESULTS

0-4 = Not Likely Mold Sickness

5-9 = Possible Mold Sickness

10+ = Probable Mold or Biotoxin Sickness

OTHER THINGS TO CONSIDER:

- LYME DISEASE, MSIDS, TICK-BORNE COINFECTIONS (USE HORROWITZ MSIDS-LYME QUESTIONNAIRE)
- OTHER ENVIRONMENTAL TOXINS (IE: MERCURY, LEAD, PM2.5, GLYPHOSATE, PESTICIDES, VOCs)
- INTESTINAL PARASITES, CHRONIC VIRAL SYNDROMES, OR OTHER STEALTH INFECTIONS
- FOOD SENSITIVITIES
- CVIDS OR IMMUNODEFICIENCY SYNDROMES

This tool is intended as a clinical information aid, and is not intended to diagnose or treat disease. Symptoms listed have been reported in mold illness patients. Not all symptoms have been proven in studies.