

# 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.