

Thank you for prioritizing your health and taking the time to complete this packet. It has been carefully designed to serve as a valuable tool in developing a personalized strategy for addressing your health needs.

The home testing packet includes several components that will help us gain insights into your health. These components consist of a Candida Questionnaire, Candida Spittle Test, Thyroid Under Arm Test, Adrenal Fatigue Questionnaire, and a Symptom Tracker/ Inflammation Calculator. Inside the packet, you will find clear directions for each of these assessments and tests.

To ensure you have a backup of your paperwork, we strongly recommend taking a picture of the completed packet. This precautionary step will prove useful if you accidentally leave the physical copy at home. The information you provide in this packet is crucial for our doctors during your visit. It plays a vital role in helping them gain a comprehensive understanding of your specific needs, enabling them to provide accurate recommendations.

Should you require any assistance or clarification regarding the completion of any of the assessments or questionnaires, please don't hesitate to reach out to our office. We are available to provide guidance and ensure that you complete the packet accurately.

Lastly, remember to bring the completed packet, either in physical form or as a picture, to your appointment. The information contained within it will be instrumental in shaping the course of your care, as our doctors rely on it to deliver the best possible treatment tailored to your unique health requirements.

Candida Questionnaire

Calculate the sum of points for each question and determine the overall total.

Questions	YES	NO
1. Have you taken repeated or prolonged courses of antibacterial drugs?	4	0
2. Have you been bothered by recurrent vagina, prostate or urinary infections?	3	0
3. Do you feel "sick all over," yet the cause hasn't been found?	2	0
4. Are you bothered by hormone disturbances? (including PMS, menstrual irregularities, sexual dysfunction, sugar craving, low body temperature, or fatigue)	2	0
5. Are you unusually sensitive to tobacco smoke, perfumes, and other chemical odors?	2	0
6. Are you bothered by memory or concentration problems?	2	0
7. Have you taken prolonged courses of prednisone or other steroids?	1	0
8. Have you taken birth control for more than 3 years?	1	0
9. Do you suffer with constipation, diarrhea, bloating or abdominal pain?	1	0
10. Does your skin itch, tingle or burn, is it unusually dry; or are you bothered by rashes?	1	0
11. When you wake up, do you have a white coating on your tongue?	1	0
Total	<input type="text"/>	

Adrenal Fatigue Test

Check all the boxes that apply to you. Add up the total and place in the box below.

- I am frequently tired.
- I feel tired even after 8 to 10 hours of sleep.
- I am chronically stressed.
- It is difficult for me to handle stress.
- I am a night-shift worker.
- I work long hours.
- I have little relaxation time during my days.
- I get headaches frequently.
- I don't exercise consistently.
- I am or have been an endurance athlete (or participate in CrossFit).
- I have erratic sleep patterns.
- I wake up in the middle of the night.
- I crave salt.
- I have high sugar intake.
- I have difficulty concentrating.
- I carry weight in my midsection (an apple-shape body).
- I have low blood sugar issues (hypoglycemia).
- I have irregular periods.
- I have a low libido.
- I have PMS or perimenopausal/menopausal symptoms.
- I get sick frequently.
- I have low blood pressure.
- I have muscle fatigue or weakness.
- I rely on caffeine for energy (coffee, energy shots, etc.).

Total: _____

Thyroid Underarm Test

This simple, at home test will help you get an idea about your current thyroid function. Below are the instructions to complete this test.

1. Before you go to bed, place a digital or basal thermometer on your bedside table.
2. The next morning, before getting out of bed, take your temperature under both arms.
3. Record your results below.

You can record your results here:

Right Arm Temperature: _____

Left Arm Temperature: _____

Candida Spittle Test

This simple, at home test will help shine some light on your current candida levels. Below are the instructions to complete this test.

1. Take a clear glass of tap water and place it on your bedside table before you go to bed.
2. The next morning, before you do anything, gently spit into the glass.
3. Check in to see the progress of your saliva after 15 minutes.
4. If your saliva does any variation of the three pictures below, that is a sign of candida overgrowth. If it stays grouped at the top or disperses, that is a sign of little to no candida overgrowth.



Symptom Tracker & Inflammation Calculator

Each week you will complete the symptom tracker to calculate your inflammation. Record your weekly scores in your Progress Tracker to measure your progress.

Rate the following symptoms on a scale of 0 - 4:

0 = None 1 = Some 2 = Mild 3 = Moderate 4 = Severe

Grand Total: _____

Head Total _____ <input type="checkbox"/> Headaches <input type="checkbox"/> Faintness <input type="checkbox"/> Migraines <input type="checkbox"/> Dizziness <input type="checkbox"/> Trouble Sleeping	Mind Total _____ <input type="checkbox"/> Brain Fog ___ Poor Memory <input type="checkbox"/> Impaired Coordination <input type="checkbox"/> Difficulty Deciding <input type="checkbox"/> Slurred/Stuttered Speech <input type="checkbox"/> Learning/Attention Deficit	Eyes Total _____ <input type="checkbox"/> Swollen, Red Eyes <input type="checkbox"/> Dark Circles <input type="checkbox"/> Puffy Eyes <input type="checkbox"/> Poor Vision <input type="checkbox"/> Watery, Itchy Eyes
Nose Total _____ <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Excessive Mucus <input type="checkbox"/> Stuffy/Runny Nose <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Frequent Sneezing	Ears Total _____ <input type="checkbox"/> Itchy Ears <input type="checkbox"/> Earaches/Infections <input type="checkbox"/> Drainage From Ear <input type="checkbox"/> Ringing, Hearing Loss	Mouth / Throat Total _____ <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Clear Throat Frequently <input type="checkbox"/> Sore Throat <input type="checkbox"/> Swollen Lips <input type="checkbox"/> Canker Sores
Heart Total _____ <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Fast Heart Rate <input type="checkbox"/> Chest Pain	Lungs Total _____ <input type="checkbox"/> Chest Congestion <input type="checkbox"/> Asthma, Bronchitis <input type="checkbox"/> Shortness Of Breath <input type="checkbox"/> Difficulty Breathing	Skin Total _____ <input type="checkbox"/> Acne <input type="checkbox"/> Hives, Eczema, Dry Skin <input type="checkbox"/> Hair Loss <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Excessive Sweating
Weight Total _____ <input type="checkbox"/> Overweight <input type="checkbox"/> Food Cravings <input type="checkbox"/> Inability To Lose Weight <input type="checkbox"/> Water Retention/Swelling <input type="checkbox"/> Compulsive Eating <input type="checkbox"/> Underweight	Digestion Total _____ <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Heartburn/Indigestion <input type="checkbox"/> Belching/Passing Gas <input type="checkbox"/> Intestinal/Stomach Pains <input type="checkbox"/> Diarrhea ___ Bloating	Emotions Total _____ <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Mood Swings <input type="checkbox"/> Nervousness <input type="checkbox"/> Easily Irritated
Energy Total _____ <input type="checkbox"/> Fatigue <input type="checkbox"/> Lethargy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Restlessness	Joints / Muscles Total _____ <input type="checkbox"/> Pain/Aching Joints <input type="checkbox"/> Muscle Stiffness <input type="checkbox"/> Pain/Muscle Aches <input type="checkbox"/> Weakness/Tiredness <input type="checkbox"/> Arthritis	Other Total _____ <input type="checkbox"/> Frequent Illness/Infections <input type="checkbox"/> Frequent/Urgent Urination <input type="checkbox"/> Genital Itch, Discharge