

CRISTA MOLD SCORE

Patient name, date of birth _____

Current date: _____

CHECK ALL SYMPTOMS EXPERIENCED IN THE PAST 3-6 MONTHS

CATEGORY I:

- | | | |
|---|---|---|
| <input type="checkbox"/> Brain fog | <input type="checkbox"/> Depression | <input type="checkbox"/> Clear your throat often |
| <input type="checkbox"/> Feel tired all the time | <input type="checkbox"/> Episodic/chronic dry cough | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Frequent runny nose or
blow your nose often | <input type="checkbox"/> Irritated lungs | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Blood-streaked mucous | <input type="checkbox"/> Long recovery from colds |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Nasal polyps | <input type="checkbox"/> Exhausted from exercise |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Red areas on upper palette
in the mouth | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Frequent yawning or sighing | <input type="checkbox"/> Bumps on back of throat | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Thrush | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sore or itchy ear canals | <input type="checkbox"/> Drunken feeling |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Eye irritation | <input type="checkbox"/> Bothered by loud noises | <input type="checkbox"/> Yeast infection |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Skin rash | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Changeable vision | <input type="checkbox"/> Burning skin | <input type="checkbox"/> Gas or bloating |
| <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Sensitive to sunlight | <input type="checkbox"/> Anemia | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness/can't settle | <input type="checkbox"/> Protruding veins | <input type="checkbox"/> Increased thirst |
| | | <input type="checkbox"/> Crave sweets |

TOTAL CATEGORY I 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

MY CATEGORY I SCORE: _____

CATEGORY II:

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

TOTAL CATEGORY II 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

MY CATEGORY II SCORE: _____

CATEGORY III:

- | | | |
|---|--|---|
| <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Aspergillosis | <input type="checkbox"/> Liver pain or swelling |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Interstitial cystitis |
| <input type="checkbox"/> Dysautonomia | <input type="checkbox"/> Coagulation abnormalities | <input type="checkbox"/> Kidney pain or swelling |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Atriovenous abnormalities | <input type="checkbox"/> Nephritis |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Histamine intolerance | <input type="checkbox"/> Chronic pelvic pain |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Erythema nodosum | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Hepatocellular carcinoma |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Eosinophilic esophagitis | <input type="checkbox"/> Previous or current cancer diagnosis |
| <input type="checkbox"/> Asthma that's difficult to control with medication | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Mast cell activation syndrome |
| <input type="checkbox"/> Idiopathic pneumonitis | <input type="checkbox"/> Non-celiac intestinal wall blunting | <input type="checkbox"/> Exposure to water-damaged building any time in your life |
| <input type="checkbox"/> Lung scarring or nodules | <input type="checkbox"/> Intestinal hemorrhage | |
| <input type="checkbox"/> Respiratory distress | <input type="checkbox"/> Cyclical vomiting syndrome | |

TOTAL CATEGORY III BOXES MARKED: _____

Score 1 for each box marked

MY CATEGORY III SCORE: _____

ADD ALL CATEGORY SCORES

MY MOLD RISK SCORE: _____

RESULTS

- TOTAL SCORE OF 0-3 = NOT LIKELY MOLD SICKNESS**
- TOTAL SCORE OF 4-7 = POSSIBLE MOLD SICKNESS**
- TOTAL SCORE OF 8+ = 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 OR OTHER STEALTH INFECTIONS
- CVIDS OR IMMUNODEFICIENCY SYNDROMES

This scoring 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.



DR JILL CRISTA
 support@drchrista.com
 www.drchrista.com
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