

Chiltern Aromatherapy

Do You Have A Yeast Problem?

This questionnaire is designed to help you to evaluate your susceptibility to yeast infections. Please answer each question, scoring as indicated, and adding your scores for each section together to give a total. Results are discussed at the end of the questionnaire.



Section A: History

- Have you taken tetracyclines or antibiotics for acne for 1 month or longer? Yes (35)
- Have you at any time in your life taken broad-spectrum antibiotics or other antibacterial medication for respiratory, urinary or other infections for 2 months, or in shorter courses at least 4 times within 1 year? Yes (35)
- Have you taken a broad-spectrum antibiotic drug - even in a single dose? Yes (6)
- Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis, or other problems affecting your reproductive organs? Yes (25)
- Are you bothered by memory or concentration problems - do you sometimes feel spaced out? Yes (20)
- Do you feel 'sick all over' yet, in spite of visits to many different physicians, the causes haven't been found? Yes (20)
- Have you been pregnant? Yes (5)
- 2 or more times?
- Once ? Yes (3)
- Have you taken birth control pills? Yes (15)
- for more than 2 years?
- for six months to 2 years? Yes (8)
- Have you taken steroids orally, by injection, or inhalation for more than 2 weeks? Yes (15)
- for 2 weeks or less? Yes (6)
- Does exposure to perfumes, insecticides, fabric shop odours and other chemicals provoke moderate to severe symptoms? Yes (20)
- mild symptoms? Yes (6)
- Does tobacco smoke really bother you? Yes (10)
- Are your symptoms worse on damp, muggy days or in mouldy places? Yes (20)
- Have you had athlete's foot, ring worm, jock itch or other chronic fungous infections of the skin or nails? Have such infections been severe or persistent? Yes (20)
- mild or moderate? Yes (10)
- Do you crave sugar? Yes (10)

SECTION A

TOTAL

Section B: Major Symptoms

For each of your symptoms, enter the appropriate figure in the point score column: If a symptom is
 occasional or mild score 3 points
 frequent and/or moderately severe 6 points
 severe and/or disabling 9 points

TICK **POINT SCORE**

Fatigue or lethargy?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Feeling of being “drained”?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Depression or manic depression?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Numbness, burning or tingling?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Headache ?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Muscle aches ?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Muscle weakness or paralysis ?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Pain and / or swelling in joints?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Abdominal pain?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Constipation or diahorrea?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Bloating, belching or intestinal gas?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Troublesome vaginal burning, itching or discharge?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Prostatitis?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Impotence?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Loss of sexual feeling or desire?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Endometriosis or infertility?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Cramps and / or other menstrual irregularities?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Premenstrual tension?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Attacks of anxiety or crying?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Cold hands or feet, or low body temperature?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Hypothyroidism?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Shaking or irritable when hungry?	<input type="checkbox"/> Yes	(3)	(6)	(9)
Cystitis or interstitial cystitis?	<input type="checkbox"/> Yes	(3)	(6)	(9)

SECTION B

TOTAL

Section C: Other Symptoms

For each of your symptoms, enter the appropriate figure in the point score column: If a symptom is
 occasional or mild score 1 points
 frequent and/or moderately severe 2 points
 severe and/or disabling 3 points

TICK **POINT SCORE**

Drowsiness, including inappropriate drowsiness?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Irritability?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Lack of coordination?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Frequent mood swings?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Insomnia?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Dizziness or loss of balance?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Pressure above the ears – a feeling of the head swelling?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Sinus problems, tenderness of the cheekbones or forehead?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Tendency to bruise easily?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Eczema, or itching eyes?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Psoriasis?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Chronic hives (urticaria)?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Indigestion or heartburn?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Sensitivity to milk, wheat, corn and other common foods?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Mucus in stools?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Rectal itching?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Dry mouth or throat?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Mouth rashes, including “white tongue”?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Bad breath?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Foot, hair or body odour not relieved by washing?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Nasal congestion or postnasal drip?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Nasal itching?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Sore throat?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Laryngitis, loss of voice?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Cough or recurrent bronchitis?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Pain or tightness in the chest?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Wheezing or shortness of breath?	<input type="checkbox"/> Yes	(1)	(2)	(3)
Urinary frequency or urgency?	<input type="checkbox"/> Yes	(1)	(2)	(3)

For each of your symptoms, enter the appropriate figure in the point score column: If a symptom is		TICK	POINT SCORE
occasional or mild	score 1 points		
frequent and/or moderately severe	score 2 points		
severe and/or disabling	score 3 points		
Burning on urination?		<input type="checkbox"/> Yes	(1) (2) (3)
Spots in front of eyes or erratic vision?		<input type="checkbox"/> Yes	(1) (2) (3)
Burning or tearing eyes?		<input type="checkbox"/> Yes	(1) (2) (3)
Recurrent infections or fluid in ears?		<input type="checkbox"/> Yes	(1) (2) (3)
Ear pain or deafness?		<input type="checkbox"/> Yes	(1) (2) (3)
SECTION C		TOTAL	

Total Score Section C _____ Total Score Section A _____ Total Score Section B _____

Grand Total Score _____

The Grand Total Score will help you and your therapist to decide if your health problems are 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.

LIKELY RESULT	WOMEN	MEN
Yeast-connected health problems are almost certainly present	> 180	> 140
Yeast-connected health problems are probably present	120 – 180	90 – 140
Yeast-connected health problems are possibly present	60 – 120	40 – 90
Yeasts are less apt to cause health problems	< 60	< 40

If you'd like to review your test scores, then please contact your therapist and book an appointment.

**Chiltern Aromatherapy
Langley House
Tudor Road
Hazlemere
High Wycombe, HP15 7PD**

**Phone: 01494-816651
Fax: 01494-814050**

www.wcct.org.uk

References: Crook, W.G., Candida Questionnaire and Score Sheet, 'The Yeast Connection' First Edition, Professional Books, Jackson, TN; pp 29-33 Reprinted with permission of Dr. William Crook