Total Wellness Empowerment Institute

Client Intake Form: Candida Screening Questionnaire

Client Information

- **Name:**
- **Date:**
- **Age:**
- **Gender:**
- **Occupation:**

Please rate how much the following statements applied to you:
0 = Never, Did not apply to me at all
1 = Occasionally, Applied to me to some degree or some of the time
2 = Frequently, Applied to me a considerable degree or a good part of the time
3 = Always, Applied to me very much or most of the time

Symptom Assessment

1. Do you frequently experience any of the following?
    - Digestive issues such as bloating, gas, diarrhea, or constipation
    - Cravings for sweets or carbohydrates
    - Fatigue or low energy levels
    - Brain fog, poor memory, or difficulty concentrating
    - Chronic or recurring sinus congestion
    - White coating on the tongue

2. Do you suffer from recurring vaginal yeast infections, urinary tract infections (UTIs), or athlete's foot?
3. Have you noticed persistent skin conditions such as eczema, psoriasis, or rashes?
4. Do you have a history of frequent use of antibiotics, antifungals, or corticosteroids?
5. Do you often feel a worsening of symptoms after consuming sugary or starchy foods?
6. Have you experienced mood-related symptoms like irritability, anxiety, or depression?
7. Do you have persistent joint or muscle pain without a clear cause?

Lifestyle & Diet Assessment

8. How often do you consume:
    - Sugar or sugary beverages?
    - Processed or packaged foods?
    - Alcohol?
9. Do you eat fermented foods (e.g., sauerkraut, yogurt, kefir) regularly?
10. Do you feel better when avoiding gluten, dairy, or sugar in your diet?

Health History

11. Have you had a history of:
    - Chronic infections or immune system challenges?
    - Hormonal imbalances such as irregular periods, PMS, or low libido?
12. Have you taken broad-spectrum antibiotics for extended periods or multiple courses in the past year?
13. Do you have a diagnosis of leaky gut, irritable bowel syndrome (IBS), or small intestinal bacterial overgrowth (SIBO)?
14. Do you have a history of long-term stress or poor sleep quality?

Candida-Specific Triggers

15. Do you feel worse in damp or moldy environments?
16. Have you used birth control pills or hormone replacement therapy for extended periods?
17. Have you experienced symptoms worsening with high-histamine foods (e.g., aged cheese, wine, fermented foods)?

Each question can be rated on a frequency or severity scale (e.g., **0 - Never, 1 - Occasionally, 2 - Frequently, 3 - Always**) to help calculate a total score and assess the likelihood of Candida overgrowth.

Additional Notes

Please share any additional information you feel is important regarding your emotional health, lifestyle, or recent experiences: