

Parasite questionnaire

	Never Occasionally Often Regularly		Never Occasionally Often Regularly
Do you experience restless sleep (toss or turn, or wake up often)?	0 1 2 3	Do you travel in developing nations?	0 2 4 6
Do you have acne, eczema, hives, itching, rashes, skin issues?	0 2 4 6	Do you eat pork products?	0 1 2 3
Do you have frequent diarrhea or loose stools?	0 1 2 3	Do you eat sushi and raw fish?	0 2 4 6
Do you have alternating constipation and diarrhea?	0 1 2 3	Do you sleep with pets on the bed?	0 1 2 3
Do you have SIBO (small intestinal bacterial overgrowth), or feel bloated or gassy?	0 1 2 3	Do you experience bed-wetting?	0 1 2 3
Do you have bowel urgency or occasional accidents?	0 1 2 3	Do you frequently vomit?	0 1 2 3
Do you experience abdominal pains, burning, or cramps?	0 1 2 3	Do you have a loss of appetite?	0 1 2 6
Do you have rectal and/or anal itching?	0 2 4 6	Are you hungry all the time, bottomless pit, hungry after meals?	0 2 4 6
Do you have anal fissures (small, painful tears or cracks)?	0 2 4 6	Do you have strong sugar and processed food cravings?	0 1 2 3
Do you have stomach or small intestinal ulcers or lesions?	0 1 2 3	Do you have asthma or breathing problems?	0 2 4 6
Do you grind your teeth when sleeping?	0 2 4 6	Do you have pain in belly button area (umbilicus)?	0 1 2 4
Do you pick your nose, or have excess boogers in your nose or scab-like boogers?	0 2 4 6	Do you have blurry, unclear vision?	0 1 2 3
Do you bite your fingers?	0 2 4 6	Do you have eye floaters?	0 2 4 6
Do you have headaches/migraines?	0 1 2 3	Do you have lethargy and apathy (disinterest)?	0 1 2 3
Are you irritable for no apparent reason?	0 2 4 6	Do you have menstrual problems?	0 1 2 3
Do you have a mood disorder, anxiety, depression, or suicidal thoughts?	0 1 2 3	Do you have dry lips?	0 1 2 3
Do you have hyperactive tendencies (nervousness)?	0 1 2 3	Do you drool while asleep?	0 1 2 3
Do you have dark circles under your eyes?	0 1 2 3	Do you have occult blood in stool (from lab test)?	0 1 2 3
Do you need extra sleep and wake up unrefreshed?	0 2 4 6	Do you swim in creeks, lakes, or rivers?	0 2 4 6
Do you have allergies and/or food sensitivities?	0 1 2 3	Do you have a history of giardia, pinworms, or other parasites?	N Y 6
Do you get fevers of unknown origin?	0 2 3 4	Do you work in childcare?	N Y 6
Do you experience night sweats (not menopausal)?	0 1 2 3	Do you have a history of or currently have cancer?	N Y 20
Do you kiss your pets or allow pets to lick your face?	0 1 2 3		
Do you sleep with pets on your bed?	0 1 2 4		
Do you experience an increase of symptoms around a full moon?	0 2 6 8		
Do you have anemia (low iron/hemoglobin on blood test)?	0 1 2 4		
Do you have iron deficiency?	0 2 4 6		
Do you have vitamin B6 deficiency?	0 2 4 6		
Do you have zinc deficiency and/or white spots on nails?	0 2 4 6		
Do you have frequent colds, flu, or sore throats?	0 1 2 3		

Parasite Infection Total

GREEN	YELLOW	RED
0-46	47-96	97-242

Instructions

Rate each of the questions to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number provided next to your answer. Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.