

PATIENT INSTRUCTION SHEET

NAME: _____

Date: _____

Basal Temperature Test:

Using a mercury thermometer take a 5 minute, underarm temperature reading for 7 days first thing before rising.
 NOTE: Your temperature must be taken before any activity occurs in the morning. Place the thermometer at you beside so that you can reach it without having to get up. Place the thermometer under the arm for a minimum of five minutes and record the temperature in the spaces provided below.

Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____ Day 5 _____ Day 6 _____ Day 7 _____
 Temperature Average (add the temperatures and divide by 7): _____

Iodine Patch Test:

Before going to bed at night, using the painting stick in a bottle of Tincture of Iodine, apply a 3"X 3" square filled in patch to the inside of the inner thigh or abdomen. Please note the time applied in the space below. Upon arising, please note the color of the patch and the time it was observed. Please continue to note color changes until the patch has disappeared completely and note the date and time.

Application Date: _____ Time: _____ AM/PM
 Upon Arising (Circle One): Bright Yellow/Orange Pale Yellow Grayish No Color
 NO COLOR DATE: _____ Time: _____ AM/PM

Candida Sputum Test:

First thing upon arising (before putting anything into the mouth) spit sputum into a glass of water (non-chlorinated ie. spring, filtered, or distilled). Check the water every 15 minutes for up to 1 hour and record your findings below. Once you see any of the first three results, your test is complete or after one hour and the fourth statement is true, your test is complete.

- _____ Strings (like legs) traveling down into the water
- _____ "Cloudy" saliva that sinks to the bottom of the glass
- _____ "Cloudy" streaks suspended in the water
- _____ No strings and saliva is floating on the water after one hour

HCl Test (Digestion):

Begin by taking one tablet during your next meal. If there is no warming sensation in the belly, take up to six tablets during this meal. Take the tablets spaced throughout your meal. Please notice how you feel after the meal. Please indicate below the results of your test.

_____ I felt a warming sensation after _____ Tablet(s) _____ I didn't feel a warming sensation with any tablets

Apple Cider Vinegar Test:

On an empty stomach drink 2 Tablespoons of apple cider vinegar. Note the time you begin the test below. Please note the time that any pain occurs or if no pain occurs after 45 minutes, please indicate in the appropriate space.

Test Start Time: _____ AM/PM Pain Began: _____ AM/PM _____ I did not have pain within 45 minutes

7 Day Food Diary:

Write down every item that you put into your mouth with the time, date, and approximate amount. Include water, food, snacks, gum, liquids, vitamins, supplements, medications, etc.

Health Appraisal Questionnaire:

Please fill out, either online or paper copy, the Health Appraisal Questionnaire. This should take between 15 and 30 minutes to complete.