Toxicity Questionnaire

The toxicity Questionnaire is designed to aid your practitioner in assessing your potential need for a purification program

Rate each line based upon your health status of the last 90 days….

Circle the Corresponding number:

0 **Rarely or Never Experience the Symptom**

1 **Occasionally Experience the Symptom- Effect is NOT Severe**

2 **Occasionally Experience the symptom- Effect is Severe**

3 **Frequently Expe-rience Symptom- Effect is NOT Severe**

4 **Frequently Expe-rience- Effect is Severe**

1. Digestion

A.	Nausea &/or Vomiting	0 1 2 3 4
B.	Diarrhea	0 1 2 3 4
C.	Constipation	0 1 2 3 4
D.	Bloated feeling	0 1 2 3 4
E.	Belching/Flatulence	0 1 2 3 4
F.	Heartburn	0 1 2 3 4
G.	Tired after eating	0 1 2 3 4

2. Emotions

A.	Mood swings	0 1 2 3 4
B.	Anxiety/Nervousness	0 1 2 3 4
C.	Fearful	0 1 2 3 4
D.	Anger or irritable	0 1 2 3 4
E.	Depression	0 1 2 3 4
F.	Easily overwhelmed	0 1 2 3 4
G.	Poor concentration	0 1 2 3 4
H.	Disinterest or apathy	0 1 2 3 4

Energy/Activity

A.	Fatigue/Sluggishness	0 1 2 3 4
B.	Restless	0 1 2 3 4
C.	Hyperactive	0 1 2 3 4
D.	Insomnia	0 1 2 3 4
E.	Startled awake @ night	0 1 2 3 4

Mind

A.	Poor Memory	0 1 2 3 4
B.	Confusion	0 1 2 3 4
C.	Poor coordination	0 1 2 3 4
D.	Difficulty making decisions	0 1 2 3 4
E.	Slurred speech	0 1 2 3 4
F.	Learning disabilities	0 1 2 3 4

Weight

A.	Cravings	0 1 2 3 4
B.	Compulsive eating	0 1 2 3 4
C.	Over weight	0 1 2 3 4
D.	Weight loss	0 1 2 3 4
E.	Water retention	0 1 2 3 4

Eyes

A.	Watery or itchy	0 1 2 3 4
B.	Swollen/red or sticky	0 1 2 3 4
C.	Dark circles under	0 1 2 3 4
D.	Puffy under eyes	0 1 2 3 4
E.	Sunken in	0 1 2 3 4
F.	Bulging out	0 1 2 3 4
G.	Blurred or tunnel vision	0 1 2 3 4

Ears

A.	Itchy	0 1 2 3 4
B.	Drainage from ears	0 1 2 3 4
C.	Earaches	0 1 2 3 4
D.	Ear infections	0 1 2 3 4
E.	Ringing in ears	0 1 2 3 4
F.	Hearing loss	0 1 2 3 4

Nose

A.	Excessive mucus	0 1 2 3 4
B.	Stuffy	0 1 2 3 4
C.	Hay fever/allergy	0 1 2 3 4
D.	Sneezing attacks	0 1 2 3 4
E.	Chronic sinus prob.	0 1 2 3 4

Page Total _____

Head

A.	Headaches	0 1 2 3 4
B.	Dizziness	0 1 2 3 4
C.	Faintness	0 1 2 3 4
D.	Pressure	0 1 2 3 4

Lungs

A. Asthma or bronchitis	0 1 2 3 4
B. Shortness of breath	0 1 2 3 4
C. Difficulty breathing	0 1 2 3 4
D. Chest congestion	0 1 2 3 4
E. Pressure/Tightness	0 1 2 3 4

Heart

A.	Chest Pain	0 1 2 3 4
B.	Skipped heart beat	0 1 2 3 4
C.	Rapid heart beat	0 1 2 3 4
D.	Irregular heart beat	0 1 2 3 4
E.	Cold hands &/or feet	0 1 2 3 4

Mouth/Throat

A.	Chronic coughing	0 1 2 3 4
B.	Gag easily	0 1 2 3 4
C.	Need to clear throat	0 1 2 3 4
D.	Canker sores	0 1 2 3 4
E.	Swollen or discolored tough, lips, gums, etc	0 1 2 3 4

Scoring:

* Would benefit from a cleanse

** Definite need to detox

*** Toxic Alert!

Skin/Hair

A.	Excessive sweating	0 1 2 3 4
B.	Moist hands	0 1 2 3 4
C.	Dry skin/hair	0 1 2 3 4
D.	Hair loss	0 1 2 3 4
E.	Acne	0 1 2 3 4
F.	Rashes	0 1 2 3 4
G.	Flushing of face	0 1 2 3 4

Joints/Muscles

A.	Pain or aches in joints	0 1 2 3 4
B.	Pain or aches in musc.	0 1 2 3 4
C.	Feeling of weakness or tiredness	0 1 2 3 4
A.	Burning pain	0 1 2 3 4
B.	Recurrent back aches	0 1 2 3 4
C.	Stiffness or limited movement	0 1 2 3 4
A.	Rheumatoid arthritis	0 1 2 3 4
B.	Osteoporosis	0 1 2 3 4

Other

A.	Frequent infections	0 1 2 3 4
B.	Frequent sickness	0 1 2 3 4
C.	Swollen glands	0 1 2 3 4
D.	Frequent or urgent need to urinate	0 1 2 3 4
E.	Genital itch &/or discharge	0 1 2 3 4

Page Total _____

* Pages 1 & 2 equal 40

** Pages 1 & 2 equal 60

*** Pages 1 & 2 over 80

Circle the corresponding number based upon your environmental exposure over the last 120 days

0	Never	1	Rarely	2	Monthly/Moderately	3	Weekly /Definite Reaction	4	Daily/Sever

Risk or Exposure

A. Frequency of prescription drugs 0 1 2 3 4

- Side effects are: (Experience side effects but mildly– add 1 point, Side effects are severe-add 3 points) . _____

B. Frequency of over the counter drugs 0 1 2 3 4

C. Do you have adverse reactions to caffeine 0 1 2 3 4

D. Do you develop symptoms upon exposure to fragrance, exhaust, or other chemicals 0 1 2 3 4

E. Do you have a history of significant or frequent exposure to weed spray, insecticides, paint fumes, or any other harsh chemicals? 0 1 2 3 4

Yeast/Candida Evaluation– Short Version

Add the number indicated for each YES answer:

A. Have you taken antibiotics more than once in the past year?.....35

B. Have you had vaginitis/ prostatitis within the past two years..... 20

C. Chronic or persistent urinary tract or vaginal/prostate infections 35

D. Have you taken any form of cortisone type drug for more than two weeks 15

E. Does exposure to new carpet, strong odors, fragrance etc. cause:

1. Mild reactions 5
2. moderate to severe symptoms 20

F. Does tobacco smoke really bother you? 10

G. . Have you had athlete's foot, “jock itch”, ring worm, or other fungal related infections of the skin or nails?

1. mild to moderate 10
2. Persistent or severe 20

H.. Do you crave sugar 10

I. Do you crave breads 10

J. Do you crave alcoholic beverages 10

Enter the rating for each symptom below. **Occasional** or **Mild– 1**, **Frequent** or **moderately severe– 2**, **Sever-3**

A. Muscle or joint stiffness, aches, cramps, or soreness for no apparent reason ....._____

B. Feeling “spacey”, drained, apathetic, irritable, fidgety, incardinated, moody, etc....._____

C. Slow to heal, Failing Vision, dizzy ....._____

D. Bad breath, , dry mouth, heart burn, bloating, constipation or diarrhea....._____

E. Rashes, blisters, bleeding gums, sore or itching throat ....._____

F. Pressure, tightness, or pain in chest, cough, wheezing ...._____

Women Only

A. More than two pregnancies 5

B. Have you taken birth control pills for more than two years 15

Scoring: **40** points– health could **possibly** be effected **60**– health is **probably** endangered **90+**– **definitely** endangered