

NAME: \_\_\_\_\_

# Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a clinical purification program.

## Section I: Symptoms

Rate each of the following based upon your health profile for the past 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 Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

### 1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloating feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4
<b>Total:</b>	_____

### 2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4
<b>Total:</b>	_____

### 3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4
<b>Total:</b>	_____

### 4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4
<b>Total:</b>	_____

### 5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4
<b>Total:</b>	_____

### 6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4
<b>Total:</b>	_____

### 7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4
<b>Total:</b>	_____

### 8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4
<b>Total:</b>	_____

### 9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4
<b>Total:</b>	_____

### 10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4
<b>Total:</b>	_____

### 11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4
<b>Total:</b>	_____

### 12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4
<b>Total:</b>	_____

### 13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Rheumatoid arthritis	0 1 2 3 4
c. Osteoarthritis	0 1 2 3 4
d. Stiffness or limited movement	0 1 2 3 4
e. Pain or aches in muscles	0 1 2 3 4
f. Recurrent back aches	0 1 2 3 4
g. Feeling of weakness or tiredness	0 1 2 3 4
<b>Total:</b>	_____

### 14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4
<b>Total:</b>	_____

### 15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4
<b>Total:</b>	_____

Section I Total: \_\_\_\_\_

## Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a - 16f below.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily
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- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| a. How often are strong chemicals used in your home?<br>(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wash, window cleaners, etc.) | 0 | 1 | 2 | 3 | 4 |
| b. How often are pesticides used in your home?  | 0 | 1 | 2 | 3 | 4 |
| c. How often do you have your home treated for insects?   | 0 | 1 | 2 | 3 | 4 |
| d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office?                              | 0 | 1 | 2 | 3 | 4 |
| e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics?  | 0 | 1 | 2 | 3 | 4 |
| f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?   | 0 | 1 | 2 | 3 | 4 |

Total: \_\_\_\_\_

17. Circle the corresponding number for questions 17a-17b below.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change
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- |   |   |   |   |   |
|---|---|---|---|---|
| a. Have you noticed any negative change in your health since you moved into your home or apartment? | 0 | 1 | 2 | 3 |
| b. Have you noticed any change in your health since you started your new job?                       | 0 | 1 | 2 | 3 |

Total: \_\_\_\_\_

18. Answer yes or no and circle the corresponding number for questions 18a - 18d below.

- |   | No | Yes |
|---|----|-----|
| a. Do you have a water purification system in your home?            | 2  | 0   |
| b. Do you have any indoor pets?                                     | 0  | 2   |
| c. Do you have an air purification system in your home?             | 2  | 0   |
| d. Are you a dentist, painter, farm worker, or construction worker? | 0  | 2   |

Total: \_\_\_\_\_

Section II Total: \_\_\_\_\_