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TOXICITY QUESTIONNAIRE

This toxicity questionnaire is designed to help you determine whether you might be a good candidate for our 21 Day Detoxification Program.

SECTION 1: SYMPTOMS

0	1	2	3	4
Rarely or Never Experience the Symptom	Occasionally Experience the Symptom, Effect NOT Severe	Occasionally Experience the Symptom, Effect Severe	Frequently Experience the Symptom, Effect NOT Severe	Frequently Experience the Symptom, Effect Severe

DIGESTIVE

Symptom	Score
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. Bloated Feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4
Total:	______

EARS

Symptom	Score
a. Itchy ears	0 1 2 3 4
b. Earaches or ear infection	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing or hearing loss	0 1 2 3 4
Total:	______

HEAD

Symptom	Score
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
Total:	______

LUNGS

Symptom	Score
a. Chest congestion	0 1 2 3 4
b. Asthma or brochitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4
Total:	______

EYES

Symptom	Score
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
Total:	______

HEART

Symptom	Score
a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4
Total:	______

ENERGY/ACTIVITY

Symptom	Score
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
Total:	______

EMOTIONS

Symptom	Score
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 disinterest	0 1 2 3 4
Total:	______

WEIGHT

Symptom	Score
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
Total:	______

OTHER

Symptom	Score
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
Total:	______

SKIN

Symptom	Score
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
Total:	______

MOUTH/THROAT

Symptom	Score
a. Chronic Coughing	0 1 2 3 4
b. Gagging or frequent need to clear your throat	0 1 2 3 4
c. Swollen or discolored tongue, gums	0 1 2 3 4
d. Canker sores	0 1 2 3 4
Total:	______

MIND

Symptom	Score
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
Total:	______

JOINTS/MUSCLES

Symptom	Score
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. Pains 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
Total:	______

SECTION 1 TOTAL: ______

SECTION II: RISK OF EXPOSURE

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

Circle the corresponding number for the questions below.

0	1	2	3	4
Never	Rarely	Monthly	Weekly	Daily

Question	
a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, 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, overstufed furniture, tobacco smoke, mothballs, incense or varnish in your home?	0 1 2 3 4
e. How often are you exposed to nail polish, hairspray, perfume 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:	________

Circle the corresponding number for the questions below.

0	1	2	3
No	Mild Change	Moderate Change	Drastic Change

Question	
a. Have you noticed any negative change in your health since you moved into your house or apartment?	0 1 2 3
b. Have you noticed any negative change in your health since you started your new job?	0 1 2 3
Total:	________

Answer yes or no and circle the corresponding number for the questions below.

YES	NO

Question	YES	NO
a. Do you have a water purification system in your home?	0	2
b. Do you have any indoor pets?	2	0
c. Do you have an air purification system in your home?	0	2
d. Are you a dentist, painter, farm worker, or construction worker?	2	0
Total:	________	

SECTION II TOTAL: ______

GRAND TOTAL (Section I & II)

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at a grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a 21-Day Detoxification Program.

CALL TODAY

TO START YOUR 21-DAY DETOXIFICATION PROGRAM & FEEL BETTER!

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