Name: Date:

Toxicity Questionnaire

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

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

Total: _____

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

Total: _____

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

Total: _____

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

Total: _____

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

Total: _____

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

Total: _____

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

Total: _____

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

Total: _____

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

Total: _____

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

Total: _____

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

Total: _____

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

Total: _____

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

Total: _____

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

Total: _____

Section I Total: _____

Name: Date:

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

Section 2: Chemical and Environmental Exposure

Rate each of the following from 0 to 3. If it does not apply, put a 0.
1= few times a month 2= weekly 3= daily or almost daily

A. Home/ Work Environment

___ 1. How often do you eat out in a restaurant?
___ 2. How often do you eat fast food?
___ 3. How often do you cook with vegetable oils?
___ 4. How often do you prepare/eat boxed meals?
___ 5. How often do you eat frozen meals?
___ 6. How often do you use margarine or other processed spreads?
___ 7. How often do you use artificial sweeteners?
___ 8. How often do you drink flavored drinks with food coloring?
___ 9. How often do you drink carbonated drinks?
___ 10. How often do you drink diet drinks?
___ 11. How often do you eat candy with food coloring?
___ 12. How often do you eat canned soups?
___ 13. How often do you eat microwave popcorn?
___ 14. How often do you use plastic containers to store your food?
___ 15. How often do you use perfume or cologne?
___ 16. How often do you use antibacterial soaps?
___ 17. How often do you take prescription medications?
___ 18. How often do you wear cosmetics?
___ 19. How often do you color, perm or straighten your hair?
___ 20. How often do you burn candles in your home or office?
___ 21. How often do you use air fresheners?
___ 22. How often do you use wood cleaners or polishes?
___ 23. How often do you use mothballs in your home?
___ 24. How often do you use ammonia for cleaning?
___ 25. How often do you use bleach (chlorine) in your laundry or for cleaning?
___ 26. How often do you use scented laundry detergent, softeners or dryer sheets?
___ 27. How often do you use powdered, liquid or foam scrubbing solution/ cleaners in your house?
___ 28. How often do you use wood to heat your home?
___ 29. How often are you exposed to smog?
___ 30. How often do you park your vehicle in a garage attached to the home you live in?

___ Section A Total

B. What has your exposure been to any of the following?

Rate each of the following from 0 to 3. If it does not apply, put a 0.
1 = few times a month 2= weekly 3= daily or almost daily

___ 1. Fertilizers
___ 2. Pesticides
___ 3. Rodenticides
___ 4. Herbicides
___ 5. Fungicides
___ 6. Paints and paint thinners
___ 7. Wood preservatives or stains
___ 8. Alloys (e.g., jewelry making)
___ 9. Dyes (e.g., textiles)
___ 10. Other

___ Section B total

C. Have you ever worked in any of the following areas?

(3= yes, 0= no)

___1. Chemical processing
___2. Electroplating
___3. Soldering
___4. Welding
___5. Metal cutting
___6. Leather tanning
___7. Fireworks
___8. Metal smelting
___9. Photographic darkroom
___10. Hair salon
___11. Nail salon
___12. Other

___Section C total

D. General Miscellaneous Exposure

___1. Have you ever worked in a mine?
(3= yes, 0= no)
___2. Have you ever had silver amalgam fillings in your teeth?
(3= yes, 0=no)
___3. Do you have any tattoos with colored ink?
(3= yes, 0= no) If yes, please circle which: red yellow green white blue black
___ 4 Do you receive flu shots or other vaccinations?
(3= yes, 0= no)
___5. Do you have any other type of metal in your mouth?
(3= yes, 0= no)
___6. Do you currently smoke cigarettes?
(3= yes, 0= no)
___ If not, have you smoked cigatettes in the past? (2= yes, 0= no)
___7. Do you currently use any other type of tobacco products?
(3= yes, 0= no)
___ If not, have you used any other type of tobacco product in the past? (2= yes, 0= no)

___8. Are you exposed to secondhand smoke?
(3= yes, 0= no)
___9. Does your home, work, school or car have a damp or mildew smell?
(3= yes, 0= no)
___10. Have you ever had water damage in your home, work or school?
(3= yes, 0= no)
___11. Does spending time in your basement cause or worsen your symptoms?
(3= yes, 0= no)
___12. Does spending time in a different location change your symptoms? If so, are they better or worse?
(3= yes, 0= no)
___13. Do you develop symptoms when you smell perfume, cologne or strong odors?
(3= yes, 0= no)

___ Section D total

E. Water

1. Where does your primary water source come from? (please circle)
municipal well home filtering system bottled other:_____

2. How many glasses of water do you drink daily? 0 1 2 3 4 5 6 7 8 9 10

Please total up each section and list the total below:

____ Total for section A

____ Total for section B

____ Total for section C

____ Total for section D

____ Grand total

Please return completed form to the doctor.