Toxicity Questionaire (Based on last 90 days)

Name:______ Sex: M F Age:_____ Date:_____

0 = 1	Rarely or neve	out is not severe $4 = Frequentl$	ly but is not se	evere		
Cognitive		Energy Level		Lungs		
Confusion	0 1 2 3 4	Can't relax	0 1 2 3 4	Asthma, Bronchitis	0 1 2 3 4	
Decisions are difficult		Hyperactivity	0 1 2 3 4	Chest congestion/mucous	0 1 2 3 4	
Learning disabilities	0 1 2 3 4	Insomnia	0 1 2 3 4	Difficulty breathing	0 1 2 3 4	
Poor concentration		Tired most of the time	0 1 2 3 4	Shortness of breath	0 1 2 3 4	
Poor coordination		Wakes abruptly at night	0 1 2 3 4	Total	<u>:</u>	
Poor memory	0 1 2 3 4	Total:		Nose		
Slurred speech	0 1 2 3 4	Eyes		Bouts of sneezing	0 1 2 3 4	
Stuttering/stammering		Distorted vision	0 1 2 3 4	Excessive mucous	0 1 2 3 4	
		Puffy and/or red eyelids		History of infections	0 1 2 3 4	
Total:			0 1 2 3 4	Nasal congestion		
Selching or passing gas	0 1 2 3 4	Watery, itchy, bloodshot	0 1 2 3 4	Seasonal allergies	0 1 2 3 4	
Bloated/discomfort	0 1 2 3 4	Total:			:	
	0 1 2 3 4	Head		Oral		
leartburn/acid reflux	0 1 2 3 4	Disorientation/dizzy	0 1 2 3 4	Canker/fever blisters	0 1 2 3 4	
oose bowels	0 1 2 3 4	Headaches	0 1 2 3 4	Chronic coughing	0 1 2 3 4	
Jausea and/or vomiting	0 1 2 3 4	Light headed	0 1 2 3 4	Constant throat congestion	0 1 2 3 4	
ood allergies	0 1 2 3 4	Chemical sensitivity		Tongue/gums/lip problems	0 1 2 3 4	
Total:		Total:		Total:		
ars		Heart		Skin		
Prainage	0 1 2 3 4	Chest pain	0 1 2 3 4	Acne/blemishes	0 1 2 3 4	
nfection or aching	0 1 2 3 4	Rapid heartbeat	0 1 2 3 4	Excessive perspiration	0 1 2 3 4	
chy sensations	0 1 2 3 4	Skipped heartbeat	0 1 2 3 4	Flushing or rosacea	0 1 2 3 4	
Linging/vertigo	0 1 2 3 4	Total:		Hives, rashes, or dry skin	0 1 2 3 4	
Total	:	Joints/Muscles		Thinning or hair loss	0 1 2 3 4	
motions		Feeling weak and/or tired	0 1 2 3 4	Total:_		
anxiety for no reason	0 1 2 3 4	Osteoarthritis	0 1 2 3 4	Weight Management		
apathy/lethargy	0 1 2 3 4	Pain/aches in joints	0 1 2 3 4	Binge eating/drinking	0 1 2 3 4	
ritability or anger	0 1 2 3 4	Pain/aches in muscles	0 1 2 3 4	Compulsive eating	0 1 2 3 4	
flood changes	0 1 2 3 4	Recurrent back aches	0 1 2 3 4	Craves certain foods	0 1 2 3 4	
adness or depression	0 1 2 3 4	Rheumatoid arthritis	0 1 2 3 4	Fluid retention	0 1 2 3 4	
ense of no purpose	0 1 2 3 4	Stiff/limited movement	0 1 2 3 4	Overweight	0 1 2 3 4	
requent illness	0 1 2 3 4	m . 1		Underweight	0 1 2 3 4	
Total:		Total:				
		Total of Page 1:				

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

Circle the corresponding number for each of the below.

0 = Never, 1 = Rarely, 2 = Monthly, 3 = Weekly, 4 = Daily

1) How often are cleaning chemicals (including bleach, disinfectants, cleaners) used in your home?		1	2	3	4
2) How often are you exposed to dust, overstuffed furniture, smoke, incense in home or office?	0	1	2	3	4
3) How often do you use nail polish, perfume, hair spray, other cosmetics?	0	1	2	3	4
4) How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?	0	1	2	3	4
5) How often is the inside of your home treated with pesticides?	0	1	2	3	4
6) How often is the outside of your home treated with pesticides?	0	1	2	3	4

Total:		
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Circle the corresponding number for each of the below.

0 = No, 1 = Mild Change, 2 = Moderate Change, 3 = Drastic Change

1) Have you noticed any negative change in your current health since you moved into your home?	0	1	2	3
2) Have you noticed any negative change in your current health at your job?	0	1	2	3

Total:_____

Answer **YES** or **NO** and circle the corresponding number for the questions below.

	YES	NO
1) Do you have a water purification system in your home?	0	2
2) Do you have an air purification system in your home?	0	2
3) Do you have any indoor pets?	2	0
4) Are you a dentist, painter, farm worker, construction worker, or work in a nail/hair salon?	2	0

Total:	

Total Page 2:_____

Total from page 1:_____ Total from page 2:_____ Total of both pages:_____

Add all the numbers on page 1 and page 2 and then total both pages. You may benefit from a detoxification program if your grand total is more than 36, or any individual section totals 6 or more.

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