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: ____

Section 11: Chemical and Environmental Exposure

Part A. Home/Work Environment

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. 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?

____ Part A Total

Part 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

____ Part B Total

Part 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

____ Part C Total

Part 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)
____3a. Do you have any tattoos with colored ink? (3= yes, 0= no)
____3b. 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? (2= yes, 0= no)
____7a. Do you currently use any other type of tobacco products? (3= yes, 0= no)
____7b. If not, have you smoked cigarettes 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)

____ Part D Total

Part E. Water

1. Where does your primary water source come from? (please circle)
   Municipal Well Home Filtering System Bottled Other:_____

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

Please total up each part and list the total below:

___ Total for Part A
___ Total for Part B
___ Total for Part C
___ Total for Part D

___ Grand Total