Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient or client's potential need for a Clinical Purification™ program

Section I: Symptoms

Rate each of the following symptoms based upon your health profile for the past 90 days.

Mark 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, ear infections	0	1	2	3	4
c. Drainage from ear	0	1	2	3	4
d. Ringing in ears, hearing loss	0	1	2	3	4
Total					

3. EMOTIONS

a. Mood swings	0	1	2	3	4
b. Anxiety, fear, 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. Apathy/ lethargy	0	1	2	3	4
Total					

4. ENERGY/ACTIVITY

a. Fatigue / 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, 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/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					

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Toxicity Questionnaire

(Section 1 Continued)

7. LUNGS

a. Chest congestion	0	1	2	3	4
b. Asthma, 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, 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, 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, limited movement	0	1	2	3	4
e. Pain, 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/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 _____

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Section II: Risk of Exposure

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

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

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

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, 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, hair spray and 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. Mark the corresponding number for questions 17a-b below.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

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 negative change in your health since you started your new job?	0 1 2 3
Total	

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

GRAND TOTAL (Section I +Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a Clinical Purification™ program.

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