

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. Bloating 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 II: Risk of Exposure

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

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

<b>0</b>	Never	<b>1</b>	Rarely	<b>2</b>	Monthly	<b>3</b>	Weekly	<b>4</b>	Daily
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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, hairspray, 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: \_\_\_\_\_

17. Circle the corresponding number for questions 17a-17b below.

<b>0</b>	No	<b>1</b>	Mild Change	<b>2</b>	Moderate Change	<b>3</b>	Drastic Change
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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 change in your health since you started your new job?	0	1	2	3

Total: \_\_\_\_\_

18. Answer yes or no and circle the corresponding number for questions 18a-18d 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: \_\_\_\_\_

**Section II 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 purification program.

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.