

# 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 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
<b>Total:</b> _____					

### 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
<b>Total:</b> _____					

### 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
<b>Total:</b> _____					

### 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
<b>Total:</b> _____					

### 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
<b>Total:</b> _____					

### 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
<b>Total:</b> _____					

### 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
<b>Total:</b> _____					

### 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
<b>Total:</b> _____					

### 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
<b>Total:</b> _____					

### 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
<b>Total:</b> _____					

### 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
<b>Total:</b> _____					

### 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
<b>Total:</b> _____					

### 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
<b>Total:</b> _____					

### 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
<b>Total:</b> _____					

### 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
<b>Total:</b> _____					

**Section I Total:** \_\_\_\_\_