

# Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's 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 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
<b>Total:</b> _____					

### 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 disinterest	0	1	2	3	4
<b>Total:</b> _____					

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

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

### 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
<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:** \_\_\_\_\_

## Section II: Risk of Exposure

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

<b>16.</b>		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
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, 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			
<b>Total:</b>									

<b>17.</b>		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
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		
<b>Total:</b>							

<b>18.</b>		Answer yes or no and circle the corresponding number for questions 18a - 18d below.			
a. Do you have a water purification system in your home?	No 2	Yes 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			
<b>Total:</b>					

**Section II Total:** \_\_\_\_\_

<b>GRAND TOTAL (Section I + Section II)</b>	
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.	

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