

# 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.

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

4	Frequently Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
1	Occasionally Experience the Symptom, Effect is Not Severe
0	Rarely or Never Experience the Symptom
<b>Circle the corresponding number.</b>	

<b>1. DIGESTIVE</b>		
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>		
<b>2. EARS</b>		
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>		
<b>3. EMOTIONS</b>		
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	
<b>Total: _____</b>		
<b>4. ENERGY / ACTIVITY</b>		
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>		
<b>5. EYES</b>		
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>		
<b>6. HEAD</b>		
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>		
<b>7. LUNGS</b>		
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>		
<b>8. MIND</b>		
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>		
<b>9. MOUTH/THROAT</b>		
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>		
<b>10. NOSE</b>		
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>		
<b>11. SKIN</b>		
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>		
<b>12. HEART</b>		
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>		
<b>13. JOINTS / MUSCLES</b>		
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>		
<b>14. WEIGHT</b>		
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>		
<b>15. OTHER:</b>		
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>		
<b>Section I Total: _____</b>		

## 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.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	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.)

b. How often are pesticides used in your home?

c. How often do you have your home treated for insects?

d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office?

e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics?

f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?

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

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

0	No	1	Mild Change	2	Moderate Change	3	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.

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.