Toxicity Questionnaire

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. 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/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: _____

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, ums, 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/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: ________

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**	**Daily**

Question					
a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven & 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. Circle the corresponding number for questions 17a – 17b below.			
0 No	**1 Mild Change**	**2 Moderate Change**	**3 Drastic Change**

Question				
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 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 Clinical Purification™ program.	

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual,* Dr. Gina L. Nick. Healthcare professionals may obtain complete copies of this book at a professional discount from Standard Process Order Department at 1.800.558.8740. Patients may purchase the book through retail outlets.