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 detoxification 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
b. Diarrhea 0
c. Constipation 0
d. Bloated feeling 0
e. Belching and/or passing gas 0
f. Heartburn 0

Total: ____

2. EARS

a. Itchy ears 0
b. Earaches or ear infections 0
c. Drainage from ear 0
d. Ringing in ears or hearing loss 0

Total: ____

3. EMOTIONS

a. Mood swings 0
b. Anxiety, fear, or nervousness 0
c. Anger, irritability 0
d. Depression 0
e. Sense of despair 0
f. Uncaring or disinterested 0

Total: ____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness 0
b. Hyperactivity 0
c. Restlessness 0
d. Insomnia 0
e. Startled awake at night 0

Total: ____

5. EYES

a. Watery or itchy eyes 0
b. Swollen, reddened, or sticky eyelids 0
c. Dark circles under eyes 0
d. Blurred or tunnel vision 0

Total: ____

6. HEAD

a. Headaches 0
b. Faintness 0
c. Dizziness 0
d. Pressure 0

Total: ____

7. LUNGS

a. Chest congestion 0
b. Asthma or bronchitis 0
c. Shortness of breath 0
d. Difficulty breathing 0

Total: ____

8. MIND

a. Poor memory 0
b. Confusion 0
c. Poor concentration 0
d. Poor coordination 0
e. Difficulty making decisions 0
f. Stuttering, stammering 0
g. Slurred speech 0
h. Learning disabilities 0

Total: ____

9. MOUTH/THROAT

a. Chronic coughing 0
b. Gagging or frequent need to clear throat 0
c. Swollen or discolored tongue, gums, lips 0
d. Canker sores 0

Total: ____

10. NOSE

a. Stuffy nose 0
b. Sinus problems 0
c. Hay fever 0
d. Sneezing attacks 0
e. Excessive mucous 0

Total: ____

11. SKIN

a. Acne 0
b. Hives, rashes, or dry skin 0
c. Hair loss 0
d. Flushing 0
e. Excessive sweating 0

Total: ____

12. HEART

a. Skipped heartbeats 0
b. Rapid heartbeats 0
c. Chest pain 0

Total: ____

13. JOINTS / MUSCLES

a. Pain or aches in joints 0
b. Stiffness or limited movement 0
c. Pain or aches in muscles 0
d. Recurrent back aches 0
e. Feeling of weakness or tiredness 0

Total: ____

14. WEIGHT

a. Binge eating or drinking 0
b. Craving certain foods 0
c. Excessive weight 0
d. Compulsive eating 0
e. Water retention 0
f. Underweight 0

Total: ____

15. OTHER:

a. Frequent illness 0
b. Frequent or urgent urination 0
c. Leaky bladder 0
d. Genital itch, discharge 0

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	**4**	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

b. How often are pesticides used in your home? 0

c. How often do you have your home treated for insects? 0

d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office? 0

e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics? 0

f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? 0

g. How often do you consume nonorganic foods? 0

Total: _____

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

0	No	**1**	Mild Change	**2**	Moderate Change	**3**	Drastic Change

a. Have you noticed any negative change in your health since you moved into your home or apartment? 0

b. Have you noticed any change in your health since you started your new job? 0

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 detoxification program.