

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 |
| 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 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 |
| 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, gums, 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 or 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: _____