Whalen Integrative Wellness Solutions

Confidential Health History

Name: ____ Date:____/____/____

Home Address: ____City: __________________________State: ______

Zip: __________ Home Phone: ____/______/______ Cell Phone: ____/______/_______ Work phone: ____/______/______

Date of Birth: ____/____/_____ Age: _____ Marital Status: S M D W #of Children:_______

In case of Emergency call:____________________________________ Email: __________________________________

Permission for the office to communicate with you by email? YES NO

Your Occupation: _____________________________ Employer Name: _________________________________

Referred By: _________________________ Previous Chiropractic care? Yes No When? _________Who_____________

Is your condition due to an auto accident? ___ or work related? ___ Date of Injury_______Claim#________________

PRESENT COMPLAINTS

1.______________________________Date Started: ____/____/____ Caused by: __________________________________

Circle all that apply: Sharp Dull Constant Intermittent Radiating Numbness Tingling Weakness Spasm

What makes it better? _______________Worse? ________________ What times of day is it worse or better? _______

Does it interfere with certain activities like: Daily Routine Sleep Work Recreation Other______________

Please rate the level of pain on a scale of 1 to 10 (10 is high) 1 2 3 4 5 6 7 8 9 10

Have you seen other doctors for this condition? _______Who?____

Other Treatment? ____

Please list any tests and their dates. (MRI, CT, X-Ray, Lab, Ultrasound, etc.)

1.____/____/_____________________________________ 2.____/____/________________________________

3.____/____/___________________________________ 4. ____/____/__________________________________

Other Complaints

2.______________________________ Date Started: ____/____/____ Caused by: __________________________________

Circle all that apply: Sharp Dull Constant Intermittent Radiating Numbness Tingling Weakness Spasm

What makes it better? __________________Worse?________________ What times of day is it worse or better? ________

Does it interfere with certain activities like: Daily Routine Sleep Work Recreation Other: ______________

Please rate the level of pain on a scale of 1 to 10 (10 is high) 1 2 3 4 5 6 7 8 9 10

Have you seen other doctors for this condition? _______Who?____

Other Treatment? ____

Please list any tests and their dates. (MRI, CT, X-Ray, Lab, Ultrasound, etc.)

1.____/____/_____________________________________ 2.____/____/________________________________

PAST HEALTH HISTORY

Please list all hospitalizations, surgeries, broken bones and injuries and car accidents and the year they occurred.

____

____

Please list all current medications and duration of use including birth control pills/injections/patches and over the counter medications____

List all past, including childhood, medications, and duration of use, including oral contraceptives and antibiotics.

____

List all current vitamins, herbs, homeopathy and any other supplements.

____

Physical Chemical and Emotional Stresses play a big part in our overall health. These questions are used to identify what stresses you have experienced both in the past and presently that could be contributing to your current health condition.

CHEMICAL STRESS **Circle all that applies**

Alcohol Past Present
How often? _________________
Soft drinks Past Present
OZ per Day_________

Smoking Past Present
How often? ____________ How long? __________

Second Hand Smoke Past Present
How many years? _______________

Coffee/Tea Past Present
How often? __________________

Excessive Sugar Past Present
How often? ___________________

Artificial Sweeteners Past Present
What kind? ___________________

Junk foods Past Present
How often? ___________________

Recreational Drugs Past Present
What kind? __________________
How often? __________________

Over-the-Counter Meds. (ex. Tylenol, Advil, etc.)
Past Present
What kind? ____________________
How often? ___________________

EMOTIONAL STRESS **Circle all that applies**

Relationships Past Present
Explain____

Career Past Present
Explain____

Children Past Present
Explain____

Money Past Present
Explain____

Hectic Life Past Present
Explain____

Hold in feelings Past Present
Explain____

Verbal abuse Past Present
Explain____

Physical abuse Past Present
Explain____

Sickness or Loss of Loved One Past Present
Explain____

What do you feel is your greatest stress?
____
____

DIET HISTORY

Typical Breakfast: ____

Typical Lunch: ____

Typical Dinner: ____

Snacks: ____-_____

Water consumption: How many glasses a day? __________

What are your daily activities and hobbies? ____

What kind of exercise do you do? ____

How often? ____

FAMILY HISTORY M = Mother, F =Father S = Sibling GP = Grandparents
Cancer: ________ Stroke: __________Diabetes: ________ Arthritis: ________ Heart Disease: _____

Auto Immune Disorders: _________ Other: ____
Our priority is helping you achieve your health goals. What are your goals?

____
____

Date:________________ Patient Name ____________________________

The Holmes and Rahe Stress Scale

- Slowly, read down through the list.
- Each life event is assigned a Stress Score– the number after it.
- If this event has occurred in your life ***over the past year***, circle that stress score or write it on the corresponding line.
- If it doesn't apply to you, leave the line blank.
- At the bottom, total up the scores you have written on the lines and compare them to the Scoring Key.

Life event	Score	
Death of spouse	**100**	______
Divorce	73	______
Marital separation	**65**	______
Imprisonment	63	______
Death within family	**63**	______
Personal illness or injury	53	______
Marriage	**50**	______
Redundancy from work	47	______
Reconciliation of marriage	**45**	______
Retirement	45	______
Illness within family	**44**	______
Pregnancy	40	______
Sexual difficulties	**39**	______
New family member	39	______
Business changes or restructuring	**39**	______
Changes in financial situation	38	______
Death of close friend	**37**	______
Change of occupation	36	______
Increased conflict with spouse	**35**	______
Large mortgage or loan	31	______
Foreclosure of mortgage or loan	**30**	______
New responsibilities at work	29	______
Children leaving home	**29**	______
Trouble with in-laws	29	______
Great personal achievement	**28**	______
Spouse starts or stops work	26	______
Start or end of school or college	**26**	______
Change in living conditions	25	______

Date:___________________ Patient Name _______________________________

Change in personal habits	**24**	_______
Trouble with employer or boss	23	_______
Change in work conditions	**20**	_______
Moving house	20	_______
Changing school or college	**20**	_______
Change in recreation	19	_______
Change in church activity	**19**	_______
Change in social activity	18	_______
Moderate mortgage or loan	**17**	_______
Change in sleep patterns	16	_______
Change in number of family meetings	**15**	_______
Change in eating habits	15	_______
Holiday	13	_______
Christmas	12	_______
Minor law infringements	11	_______

Your Total Score _______

This allows you to determine the total amount of stress you are experiencing by adding up the relative stress values, known as Life Change Units (LCU), for various events.

A score of 250 or more is considered high. Persons with a low stress tolerance may find themselves overstressed with a score of 150. The test is used to determine disease susceptibility.

SCORING KEY

— These scores are a *general* measure of stress. People handle stress differently. Some are able to carry stress more than others.

Score less than **150 or Less:** You have a 37% chance of becoming seriously ill.

If your score is 150+, your health is at considerable risk.

Score between 150 to 300: You have a 51% chance of becoming seriously ill.

Score over 300: You have an 80% chance of serious illness in the next 2 years.

Adapted from the "Social Readjustment Rating Scale" by Thomas Holmes and Richard Rahe. This scale was first published in the Journal of Psychosomatic Research. 1967, vol. II p. 214.

SYSTEMS SURVEY FORM

Patient ______________________ Doctor ____________________ Date ______________

Birth Date ____/____/____ Approx Weight ____________ Vegetarian ¨ Gluten-free ¨

INSTRUCTIONS: Fill in only the circles which apply to you. Leave blank if you don't have the problem.

●○○ Fill in the circle marked 1 for MILD symptoms (occurs rarely).
○●○ Fill in the circle marked 2 for MODERATE symptoms (occurs several times a month).
○○● Fill in the circle marked 3 for SEVERE symptoms (occurs almost constantly).
○○○ **Leave circles BLANK if they don't apply to you!**

GROUP 1 - Sympathetic Dominance

#	1 2 3	Symptom
1	○○○	Acid foods upset
2	○○○	Get chilled often
3	○○○	"Lump" in throat
4	○○○	Dry mouth-eyes-nose
5	○○○	Pulse speeds after meal
6	○○○	Keyed up - fail to calm
7	○○○	Cut heals slowly
8	○○○	Gag easily
9	○○○	Unable to relax; startles easily
10	○○○	Extremities cold, clammy
11	○○○	Strong light irritates
12	○○○	Urine amount reduced
13	○○○	Heart pounds after retiring
14	○○○	"Nervous" stomach
15	○○○	Appetite reduced
16	○○○	Cold sweats often
17	○○○	Fever easily raised
18	○○○	Neuralgia-like pains
19	○○○	Staring, blinks little
20	○○○	Sour stomach often

GROUP 2 - Parasympathetic Dominance

#	1 2 3	Symptom
21	○○○	Joint stiffness on arising
22	○○○	Muscle-leg-toe cramps at night
23	○○○	"Butterfly" stomach, cramps
24	○○○	Eyes or nose watery
25	○○○	Eyes blink often
26	○○○	Eyelids swollen, puffy
27	○○○	Indigestion soon after meals
28	○○○	Always seems hungry; feels "lightheaded" often
29	○○○	Digestion rapid
30	○○○	Vomiting frequent
31	○○○	Hoarseness frequent
32	○○○	Breathing irregular
33	○○○	Pulse slow; feels "irregular"
34	○○○	Gagging reflex slow
35	○○○	Difficulty swallowing
36	○○○	Constipation, diarrhea alternating
37	○○○	"Slow starter"
38	○○○	Get "chilled" infrequently
39	○○○	Perspire easily
40	○○○	Circulation poor, sensitive to cold
41	○○○	Subject to colds, asthma, bronchitis

GROUP 3 - Sugar Handling

#	1 2 3	Symptom
42	○○○	Eat when nervous
43	○○○	Excessive appetite
44	○○○	Hungry between meals
45	○○○	Irritable before meals
46	○○○	Get "shaky" if hungry
47	○○○	Fatigue, eating relieves
48	○○○	"Lightheaded" if meals delayed
49	○○○	Heart palpitates if meals missed or delayed
50	○○○	Afternoon headaches
51	○○○	Overeating sweets upsets
52	○○○	Awaken after few hours sleep - hard to get back to sleep
53	○○○	Crave candy or coffee in afternoons
54	○○○	Moods of depression - "blues" or melancholy
55	○○○	Abnormal craving for sweets or snacks

GROUP 4 - Cardio-Vascular

#	1 2 3	Symptom
56	○○○	Hands and feet go to sleep easily, numbness
57	○○○	Sigh frequently, "air hunger"
58	○○○	Aware of "breathing heavily"
59	○○○	High altitude discomfort
60	○○○	Opens windows in closed rooms
61	○○○	Susceptible to colds and fevers
62	○○○	Afternoon "yawner"
63	○○○	Get "drowsy" often
64	○○○	Swollen ankles, worse at night
65	○○○	Muscle cramps, worse during exercise; get "charley horses"
66	○○○	Shortness of breath on exertion
67	○○○	Dull pain in chest or radiating into left arm, worse on exertion
68	○○○	Bruise easily, "black and blue" spots
69	○○○	Tendency to anemia
70	○○○	"Nose bleeds" frequent
71	○○○	Noises in head, or "ringing in ears"
72	○○○	Tension under the breastbone, or feeling of "tightness", worse on exertion

SYSTEMS SURVEY FORM - PAGE 2

GROUP 5 - Biliary / Liver

(1 2 3)

- 73 ○○○ Dizziness
- 74 ○○○ Dry skin
- 75 ○○○ Burning feet
- 76 ○○○ Blurred vision
- 77 ○○○ Itching skin and feet
- 78 ○○○ Excessive falling hair
- 79 ○○○ Frequent skin rashes
- 80 ○○○ Bitter, metallic taste in mouth in mornings
- 81 ○○○ Bowel movements painful or difficult
- 82 ○○○ Worrier, feels insecure
- 83 ○○○ Feeling queasy; headache over eyes
- 84 ○○○ Greasy foods upset
- 85 ○○○ Stools light colored
- 86 ○○○ Skin peels on foot soles
- 87 ○○○ Pain between shoulder blades
- 88 ○○○ Use laxatives
- 89 ○○○ Stools alternate from soft to watery
- 90 ○○○ History of gallbladder attacks or gallstones
- 91 ○○○ Sneezing attacks
- 92 ○○○ Dreaming, nightmare type bad dreams
- 93 ○○○ Bad breath (halitosis)
- 94 ○○○ Milk products cause distress
- 95 ○○○ Sensitive to hot weather
- 96 ○○○ Burning or itching anus
- 97 ○○○ Crave sweets

GROUP 6 - Digestive

(1 2 3)

- 98 ○○○ Loss of taste for meat
- 99 ○○○ Lower bowel gas several hours after eating
- 100 ○○○ Burning stomach sensations, eating relieves
- 101 ○○○ Coated tongue
- 102 ○○○ Pass large amounts of foul-smelling gas
- 103 ○○○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 104 ○○○ Mucous colitis or "irritable bowel"
- 105 ○○○ Gas shortly after eating
- 106 ○○○ Stomach "bloating" after

GROUP 7 - Endocrine

(A) - Hyperthyroid

(1 2 3)

- 107 ○○○ Insomnia
- 108 ○○○ Nervousness
- 109 ○○○ Can't gain weight
- 110 ○○○ Intolerance to heat
- 111 ○○○ Highly emotional
- 112 ○○○ Flush easily
- 113 ○○○ Night sweats
- 114 ○○○ Thin, moist skin
- 115 ○○○ Inward trembling
- 116 ○○○ Heart palpitates
- 117 ○○○ Increased appetite without weight gain
- 118 ○○○ Pulse fast at rest
- 119 ○○○ Eyelids and face twitch
- 120 ○○○ Irritable and restless
- 121 ○○○ Can't work under pressure

(B) - Hypothyroid

(1 2 3)

- 122 ○○○ Increase in weight
- 123 ○○○ Decrease in appetite
- 124 ○○○ Fatigue easily
- 125 ○○○ Ringing in ears
- 126 ○○○ Sleepy during day
- 127 ○○○ Sensitive to cold
- 128 ○○○ Dry or scaly skin
- 129 ○○○ Constipation
- 130 ○○○ Mental sluggishness
- 131 ○○○ Hair coarse, falls out
- 132 ○○○ Headaches upon arising, wear off during day
- 133 ○○○ Slow pulse, below 65
- 134 ○○○ Frequency of urination
- 135 ○○○ Impaired hearing
- 136 ○○○ Reduced initiative

(C) - Hyperpituitary

(1 2 3)

- 137 ○○○ Failing memory
- 138 ○○○ Low blood pressure
- 139 ○○○ Increased sex drive
- 140 ○○○ Headaches, "splitting or rending" type
- 141 ○○○ Decreased sugar tolerance

(D) - Hypopituitary

(1 2 3)

- 142 ○○○ Abnormal thirst
- 143 ○○○ Bloating of abdomen
- 144 ○○○ Weight gain around hips or waist
- 145 ○○○ Sex drive reduced or lacking
- 146 ○○○ Tendency to ulcers, colitis
- 147 ○○○ Increased sugar tolerance
- 148 ○○○ Women: menstrual disorders
- 149 ○○○ Young girls: lack of menstrual function

(E) - Hyperadrenal

(1 2 3)

- 150 ○○○ Dizziness
- 151 ○○○ Headaches
- 152 ○○○ Hot flashes
- 153 ○○○ Increased blood pressure
- 154 ○○○ Hair growth on face or body (female)
- 155 ○○○ Sugar in urine (not diabetes)
- 156 ○○○ Masculine tendencies (female)

(F) - Hypoadrenal

(1 2 3)

- 157 ○○○ Weakness, dizziness
- 158 ○○○ Chronic fatigue
- 159 ○○○ Low blood pressure
- 160 ○○○ Nails weak, ridged
- 161 ○○○ Tendency to hives
- 162 ○○○ Arthritic tendencies
- 163 ○○○ Perspiration increase
- 164 ○○○ Bowel disorders
- 165 ○○○ Poor circulation
- 166 ○○○ Swollen ankles
- 167 ○○○ Crave salt
- 168 ○○○ Brown spots or bronzing of skin
- 169 ○○○ Allergies - tendency to asthma
- 170 ○○○ Weakness after colds, influenza
- 171 ○○○ Exhaustion - muscular and nervous
- 172 ○○○ Respiratory disorders

SYSTEMS SURVEY FORM - PAGE 3

GROUP 8 - Foundational

No.	1 2 3	Symptom
173	○○○	Muscle weakness
174	○○○	Lack of Stamina
175	○○○	Drowsiness after eating
176	○○○	Muscular soreness
177	○○○	Rapid heart beat
178	○○○	Hyper-irritable
179	○○○	Feeling of a band around your head
180	○○○	Melancholia (feeling of sadness)
181	○○○	Swelling of ankles
182	○○○	Diminished urination
183	○○○	Tendency to consume sweets or carbohydrates
184	○○○	Muscle spasms
185	○○○	Blurred vision
186	○○○	Loss of muscular control
187	○○○	Numbness
188	○○○	Night sweats
189	○○○	Rapid digestion
190	○○○	Sensitivity to noise
191	○○○	Redness of palms of hands and bottom of feet
192	○○○	Visible veins on chest and abdomen
193	○○○	Hemorrhoids
194	○○○	Apprehension (feeling that something bad will happen)
195	○○○	Nervousness causing loss of appetite
196	○○○	Nervousness with indigestion
197	○○○	Gastritis
198	○○○	Forgetfulness
199	○○○	Thinning hair

FEMALE ONLY

No.	1 2 3	Symptom
200	○○○	Very easily fatigued
201	○○○	Premenstrual tension
202	○○○	Painful menses
203	○○○	Depressed feelings before menstruation
204	○○○	Menstruation excessive and prolonged
205	○○○	Painful breasts
206	○○○	Menstruate too frequently
207	○○○	Vaginal discharge
208	○	Hysterectomy / ovaries removed
209	○○○	Menopausal hot flashes
210	○○○	Menses scanty or missed
211	○○○	Acne, worse at menses
212	○○○	Depression of long standing

MALE ONLY

No.	1 2 3	Symptom
213	○○○	Prostate trouble
214	○○○	Urination difficult or dribbling
215	○○○	Night urination frequent
216	○○○	Depression
217	○○○	Pain on inside of legs or heels
218	○○○	Feeling of incomplete bowel evacuation
219	○○○	Lack of energy
220	○○○	Migrating aches and pains
221	○○○	Tire too easily
222	○○○	Avoids activity
223	○○○	Leg nervousness at night
224	○○○	Diminished sex drive

IMPORTANT

Please list the five main complaints you have in the order of their importance:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES
Any two days during the month
FEMALES HAVING MENSTRUAL CYCLES
The 2nd and 3rd day of flow OR any 5 days in a row
MALES
Any 2 days during the month

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date	Temperature
Date ________	Temperature ________
Date ________	Temperature ________
Date ________	Temperature ________
Date ________	Temperature ________
Date ________	Temperature ________
Date ________	Temperature ________
Date ________	Temperature ________

SYSTEMS SURVEY FORM - PAGE 4

Please list any medications you are taking: ☐ No Medications

____

____

____

Please list any vitamins, herbs, or supplements you are taking: ☐ No Vitamins

____

____

____

Please list any allergies you have: ☐ No Allergies

____

____

Please list any surgeries you have had in the past 12 months: ☐ No Recent Surgeries

____

____

Please list any other surgeries or medical procedures you have had: ☐ No Other Surgeries

____

____

____

TO BE COMPLETED BY DOCTOR

Blood Pressure: Recumbent ____________ Standing ____________

Pulse: Recumbent ____________ Standing ____________

Hema-Combistix Urine Readings: pH ____________ Albumin % ____________ Glucose % ____________

Occult Blood ____________ pH of Saliva ____________ pH of Stool Specimen ____________

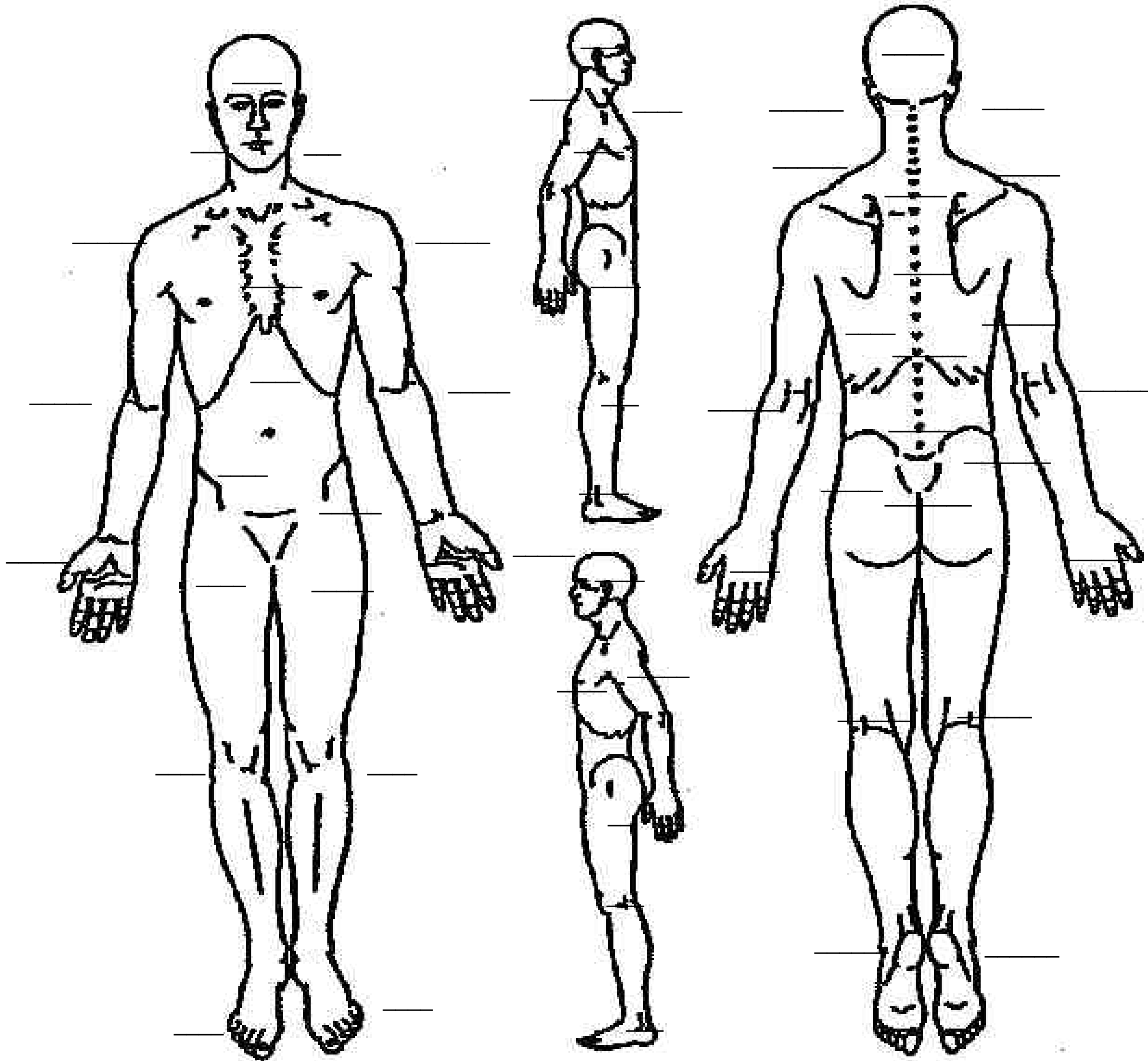
Blood Clotting Time ____________ Hemoglobin ____________ Blood Type ____________ Weight ____________

SYSTEMS SURVEY FORM - PAGE 5

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature ______________________ Date ______________

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 purification program.

Section I: Symptoms

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

Check the corresponding number for the symptoms below. (Only check one box per question.)	
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 0 1 2 3 4
- a. Nausea and/or vomiting
- b. Diarrhea
- c. Constipation
- d. Bloated feeling
- e. Belching and/or passing gas
- f. Heartburn

Total:

2. EARS 0 1 2 3 4
- a. Itchy ears
- b. Earaches or ear infections
- c. Drainage from ear
- d. Ringing in ears or hearing loss

Total:

3. EMOTIONS 0 1 2 3 4
- a. Mood swings
- b. Anxiety, fear or nervousness
- c. Anger, irritability
- d. Depression
- e. Sense of despair
- f. Uncaring or disinterested

Total:

4. ENERGY/ACTIVITY 0 1 2 3 4
- a. Fatigue or sluggishness
- b. Hyperactivity
- c. Restlessness
- d. Insomnia
- e. Startled awake at night

Total:

5. EYES 0 1 2 3 4
- a. Watery or itchy eyes
- b. Swollen, reddened, or sticky eyelids
- c. Dark circles under eyes
- d. Blurred or tunnel vision

Total:

6. HEAD 0 1 2 3 4
- a. Headaches
- b. Faintness
- c. Dizziness
- d. Pressure

Total:

7. LUNGS 0 1 2 3 4
- a. Chest congestion
- b. Asthma or bronchitis
- c. Shortness of breath
- d. Difficulty breathing

Total:

8. MIND 0 1 2 3 4
- a. Poor memory
- b. Confusion
- c. Poor concentration
- d. Poor coordination
- e. Difficulty making decisions
- f. Stuttering, stammering
- g. Slurred speech
- h. Learning disabilities

Total:

9. MOUTH/THROAT 0 1 2 3 4
- a. Chronic coughing
- b. Gagging or frequent need to clear throat
- c. Swollen or discolored tongue, gums, lips
- d. Canker sores

Total:

10. NOSE 0 1 2 3 4
- a. Stuffy nose
- b. Sinus problems
- c. Hay fever
- d. Sneezing attacks
- e. Excessive mucous

Total:

11. SKIN 0 1 2 3 4
- a. Acne
- b. Hives, rashes or dry skin
- c. Hair loss
- d. Flushing
- e. Excessive sweating

Total:

12. HEART 0 1 2 3 4
- a. Skipped heartbeats
- b. Rapid heartbeats
- c. Chest pain

Total:

13. JOINTS/MUSCLES 0 1 2 3 4
- a. Pain or aches in joints
- b. Rheumatoid Arthritis
- c. Osteoarthritis
- d. Stiffness or limited movement
- e. Pain or aches in muscles
- f. Recurrent back aches
- g. Feeling of weakness or tiredness

Total:

14. WEIGHT 0 1 2 3 4
- a. Binge eating or drinking
- b. Craving certain foods
- c. Excessive weight
- d. Compulsive eating
- e. Water retention
- f. Underweight

Total:

15. OTHER 0 1 2 3 4
- a. Frequent illness
- b. Frequent or urgent urination
- c. Leaky bladder
- d. Genital itch, discharge

Total:

Section I Total:

Section II: Risk of Exposure

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

16. Check the corresponding boxes for questions 16a - 16f below. (Only check one box per question.)									
0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

	0	1	2	3	4
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. Check the corresponding boxes for questions 17a - 17b below. (Only check one box per question.)							
0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

	0	1	2	3
a. Have you noticed any negative change in your health since you moved into your home or apartment?				
b. Have you noticed any change in your health since you started your new job?				

Total:

18. Answer yes or no and check the corresponding box for questions 18a - 18d below.

	No	Yes
a. Do you have a water purification system in your home?		
b. Do you have any indoor pets?		
c. Do you have an air purification system in your home?		
d. Are you a dentist, painter, farm worker or construction worker?		

Total:

Section II Total:	

Grand Total (Section I & II)	
Review the totals for each section, 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.