Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practioner in assessing a patients or clients potential need for a Clinical Purification program.

Section 1: Symptoms

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

0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Sympton. 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

Circle the corresponding number

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	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/sluggish	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. Confustion	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	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 1 Total

Section II: Risk of Exposure

Rate each of the following situation based upon your environmental profile for the past 120 days

Circle the corresponding number for questions 16a - 16f below

16a-f

0	**Never**	1	**Rarely**	2	**Montly**	3	**Weekly**	4	**Daily**

a. How oftten are strong chemicals used in your home	0	1	2	3	4
(disinfectants, bleaches, over and drain cleaners, furniture polish, floor wax, window cleaners, etc.)					
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,					
moth balls, 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

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

17a-b

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

Total

Answer yes or no and circle the corresponding number for questions 18a - 18d below

18a-d	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 *Clincial Purification. A Complete Treatment and Reference Manual* , Dr. Gina L. Nick