TOXICITY QUESTIONNAIRE

Name: ____

Date:____

The questionnaire helps you track your progress over time. If this is your first time taking the questionnaire, rate each of the following symptoms based upon your health profile of the past 30 days. If this is NOT your first time taking the questionnaire, mark your results from the past 48 hours only.

POINT SCALE:

0=Never or almost never
1=Occasionally have it, effect is not severe
2=Occasionally have it, effect is severe
3=Frequently have it, effect is not severe
4=Frequently have it, effect is severe

Digestive:
___Upset stomach
___Loose stool
___Difficulty with bowel movements
___Bloated feeling
___Chest or gut discomfort after eating
___Intestinal/stomach discomfort
Total____

Ears:
___Itchy ears
___Difficulty sorting out ambient noise, tinnitus
Total____

Emotions:
___Moodiness
___Feelings of anxiousness or nervousness
___Anger, easily irritated or aggressive
___Feeling blue/melancholy
Total____

Energy/Activity:
___Fatigue, sluggishness
___Feelings of indifference
___Feelings of restlessness
Total____

Eyes:
___Excess tears in eyes
___Frequent rubbing of eyes
___Change of appearance in eyelids
___Bags or dark circles under eyes
Total____

Head:
___Pressure or discomfort in the head
___Feeling dizzy
___Loss of balance during or after movement
___Migraines
Total____

Heart:
___Heart beat rhythm concerns
___Discomfort in chest
Total____

Joints/Muscles:
___Joint Discomfort
___Stiffness, lack of flexibility
___Muscle soreness or swelling
___Muscles feeling weak
Total____

Lungs:
___Coughing
___Respiratory concerns
___Difficulty breathing
___Wheezing
Total____

Mind:
___Memory concerns
___Reduced concentration
___Won’t or can’t make decisions
Total____

Mouth/Throat:
___Frequent coughing
___Frequent need to clear throat
___Mouth discomfort eating cold or acidic foods
Total____

Nose:
___Stuffy nose
___Runny nose
___Seasonal allergies
___Sneezing
___Too much mucus
Total____

Skin:
___Facial blemishes
___Red bumps or patches
___Thinning hair
___Flushing face or neck
___Excessive sweating
___Dry skin; flaking
___Moles or dark spots
Total____

Weight:
___Binge eating/emotional eating
___Being overweight
___Compulsive eating
___Craving salty foods
___Water retention
Total____

Kidney:
___Feel the need to urinate often
___Genital irritation
___Frequent waking to urinate at night
Total____

Sleep:
___Difficulty falling asleep
___Difficulty staying asleep
___Waking in middle of night
___Wake up feeling tired even if sleep well
Total____

Key to questionnaire: Add individual scores and total each category. Add category scores for a grand total.

Less than 10 = Low toxicity
10-50= Mild toxicity
50-100= Moderate toxicity
Over 100 = High toxicity

****Disclaimer: This assessment is not intended to diagnose or substitute the professional opinion of a medical doctor. Consult your healthcare provider about any questions you may have.**