Toxicity Assessment

The Toxicity Assessment is designed to aid the practitioner
in assessing the patient's need for a Detoxification Program.

SECTION I: SYMPTOMS

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

Use this guide to circle the number of your answer to the following questions:						
0 = Never						
1 = Rarely						
2 = Not severe (Occasionally experience)						
3 = Is severe (Occasionally experience)						
4 =Very severe (Frequently experience)						
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= ________				
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.	Difficulty making decisions	0	1	2	3	4
E.	Stuttering, stammering	0	1	2	3	4
F.	Slurred speech	0	1	2	3	4
G.	Learning disability	0	1	2	3	4
H.	Poor coordination	0	1	2	3	4
		TOTAL= ________				
EYES						
A.	Watery, itchy eyes	0	1	2	3	4
B.	Swollen, reddened	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= ________				
EARS						
A.	Itchy Ears	0	1	2	3	4
B.	Ear Aches / 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= ________				
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= ________				
MOUTH / THROAT						
A.	Chronic coughing	0	1	2	3	4
B.	Gagging, need to clear throat	0	1	2	3	4
C.	Swollen or discolored tongue, gums or lips	0	1	2	3	4
		TOTAL= ________				
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= ________				
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= ________				
HEART						
A.	Skipped heartbeats	0	1	2	3	4
B.	Rapid heartbeats	0	1	2	3	4
C.	Chest pains	0	1	2	3	4
		TOTAL= ________				
BOWELS / OTHER						
A.	Frequent or urgent urination	0	1	2	3	4
B.	Leaky bladder	0	1	2	3	4
C.	Frequent illness	0	1	2	3	4
		TOTAL= ________				
SKIN						
A.	Acne	0	1	2	3	4
B.	Hives, rashes or 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= ________				
JOINTS / MUSCLE						
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 muscle	0	1	2	3	4
F.	Frequent back pain	0	1	2	3	4
G.	Feeling of weakness or tiredness					
		TOTAL= ________				
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.	Under weight	0	1	2	3	4
		TOTAL= ________				
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.	Lethargy	0	1	2	3	4
		TOTAL= ________				
ENERGY						
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

		0	1	2	3	4
E.	Startled awake at night	0	1	2	3	4
		TOTAL= _______				

SECTION I TOTALS ___________________

SECTION II: RISK OF EXPOSURE

Rate each of the following based upon your health profile for the last 120 days.

Circle the corresponding number for the following questions

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	1	2	3	4
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, mothballs, 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= _______				

Answer Yes or No and circle the corresponding number for the following questions		**Y**	**N**
A.	**Do you have a water purification system in your home?**	0	2
B.	**Are pesticides used frequently in your home?**	2	0
C.	**Do you have an air purification system in your home?**	0	2
D.	**Are you a dentist, painter, farm worker or construction worker?**	2	0
		TOTAL= _______	

SECTION II TOTALS ___________________

SECTION I TOTAL =	_______
SECTION II TOTAL =	_______
GRAND TOTAL =	_______

Add up the numbers to arrive at a total for each section, and then add the totals of BOTH sections together to arrive at GRAND TOTAL. If any individual section is 6 or more, or GRAND TOTAL is 40 or more, you may benefit from a Detox program.