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: 0

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: 0

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: 0

4. ENERGY/ACTIVITY

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

Total: 0

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: 0

6. HEAD

	0	1	2	3	4
a. Headaches	☐	☐	☐	☐	☐
b. Faintness	☐	☐	☐	☐	☐
c. Dizziness	☐	☐	☐	☐	☐
d. Pressure	☐	☐	☐	☐	☐

Total: 0

7. LUNGS

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

Total: 0

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: 0

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: 0

10. NOSE

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

Total: 0

11. SKIN

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

Total: 0

12. HEART

	0	1	2	3	4
a. Skipped heartbeats	☐	☐	☐	☐	☐
b. Rapid heartbeats	☐	☐	☐	☐	☐
c. Chest pain	☐	☐	☐	☐	☐

Total: 0

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: 0

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: 0

15. OTHER

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

Total: 0

Section I Total: 0

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: 0

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: 0

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: 0

Section II Total:	0

Grand Total (Section I & II)	**0**

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.