

Name: _____

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a Clinical Purification™ program.

Section I: Symptoms

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

Circle the corresponding number.

| | |
|----------|---|
| 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

| | |
|--------------------------------|-----------|
| 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. Bloating 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 or ear infections | 0 1 2 3 4 |
| c. Drainage from ear | 0 1 2 3 4 |
| d. Ringing in ears or hearing loss | 0 1 2 3 4 |

Total: _____

3. EMOTIONS

| | |
|----------------------------------|-----------|
| a. Mood swings | 0 1 2 3 4 |
| b. Anxiety, fear, or 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. Uncaring or disinterested | 0 1 2 3 4 |

Total: _____

4. ENERGY / ACTIVITY

| | |
|----------------------------|-----------|
| a. Fatigue or 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 |
| e. Startled awake at night | 0 1 2 3 4 |

Total: _____

5. EYES

| | |
|---|-----------|
| a. Watery or 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 or 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 or 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. Confusion | 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 or 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, 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: _____

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 or limited movement | 0 1 2 3 4 |

Total: _____

| | |
|-------------------------------------|-----------|
| e. Pain or 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 or 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 I Total: _____

Section II: Risk of Exposure

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

| | | | | | | | | | |
|--|-------|---|--------|---|---------|---|--------|---|--------------|
| 16. Circle the corresponding number for questions 16a-16f below. | | | | | | | | | |
| 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, hairspray, or 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: _____ |

| | | | | | | | | | |
|---|----|---|-------------|---|-----------------|---|----------------|--|--------------|
| 17. Circle the corresponding number for questions 17a-17b below. | | | | | | | | | |
| 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 your home or apartment? | | | | | | | | | |
| | | | | | | | | | 0 1 2 3 |
| b. Have you noticed any change in your health since you started your new job? | | | | | | | | | |
| | | | | | | | | | 0 1 2 3 |
| | | | | | | | | | Total: _____ |

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|----|--------------|
| 18. Answer yes or no and circle the corresponding number for questions 18a-18d below. | | | | | | | | | |
| | | | | | | | | 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) | |
| <p>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.</p> | |

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.