# Toxicity Questionnaire

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

## Section I: Symptoms

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

| Circle the corresponding number in the following questions. | | |
|---|---|---|
| **1** | = | Rarely or Never experience the symptom |
| **2** | = | Occasionally experience the symptom, effect is **NOT** severe |
| **3** | = | Occasionally experience the symptom, effect **IS** 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.** 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, hearin gloss | 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.** Apothy / lethargy | 0 1 2 3 4 |

**TOTAL:**

| 4. ENERGY / ACTIVITY | |
|---|---|
| **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 |
| **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 | 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.** 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, need to clear throat | 0 1 2 3 4 |
| **C.** Swollen or discolored tongue, gums, lips | 0 1 2 3 4 |
| **D.** Blurred / tunnel vision | 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 |
| **B.** Hives, rashes, dry skin | 0 1 2 3 |
| **C.** Hair loss | 0 1 2 3 |
| **D.** Flushing | 0 1 2 3 |
| **E.** Excessive sweating | 0 1 2 3 |

**TOTAL:**

| 12. HEART | |
|---|---|
| **A.** Skipped heartbeats | 0 1 2 3 |
| **B.** Rapid heartbeats | 0 1 2 3 |
| **C.** Chest pains | 0 1 2 3 |

**TOTAL:**

| 13. JOINTS / MUSCLES | |
|---|---|
| **A.** Pain or aches in joints | 0 1 2 3 |
| **B.** Rheumatiod arthritis | 0 1 2 3 |
| **C.** Osteoarthritis | 0 1 2 3 |
| **D.** Stiffness, limited movement | 0 1 2 3 |
| **E.** Pain, aches in muscles | 0 1 2 3 |
| **F.** Recurrent back pain | 0 1 2 3 |
| **G.** Feeling of weakness or tiredness | 0 1 2 3 |

**TOTAL:**

| 14. WEIGHT | |
|---|---|
| **A.** Binge eating / drinking | 0 1 2 3 |
| **B.** Craving certain foods | 0 1 2 3 |
| **C.** Excessive weight | 0 1 2 3 |
| **D.** Compulsive eating | 0 1 2 3 |
| **E.** Water retention | 0 1 2 3 |
| **F.** Underweight | 0 1 2 3 |

**TOTAL:**

| 15. OTHER | |
|---|---|
| **A.** Frequent illness | 0 1 2 3 |
| **B.** Frequent or urgent urination | 0 1 2 3 |
| **C.** Leaky bladder | 0 1 2 3 |

**TOTAL:**

**Section I Total:**

# Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the last 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, 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:**

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

**0** = No **1** = Mild Change **2** = Moderate Changes **3** = Drastic Change

| | | | | | |
|---|---|---|---|---|---|
| **A.** | Have you noticed any negetive change in your health since you moved into your house or apartment? | 0 | 1 | 2 | 3 |
| **B.** | Have you noticed any negetive 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. | **Y** | **N** |
|---|---|---|---|
| **A.** | Do you have a water purification system in your home? | 0 | 2 |
| **B.** | How often are pesticides used in your home? | 2 | 0 |
| **C.** | Do you have an air prification system in your home? | 0 | 2 |
| **D.** | Are you a dentist, painter, farm worker, or construction worker? | 2 | 0 |

**TOTAL:**

| | |
|---|---|
| **Section II Total:** | |
| **Section I Total:** | |

## GRAND TOTAL {Section I & Section II} ............................................................

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 Clinical Prurification™ program.

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