TOXICITY QUESTIONNAIRE

DATE:	NAME:
SECTION I - POINT SCALE:	
0 = Never have the symptom	
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	

1. HEAD	Headaches	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Faintness	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Dizziness	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Insomnia	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○

Total ☐

2. EYES	Watery or itchy eyes	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Swollen, reddened or sticky eyelids	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Bags or dark circles under eyes	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Blurred or tunnel vision (does not include near- or far-sightedness)	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○

Total ☐

3. EARS	Itchy ears	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Earaches, ear infections	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Drainage from ear	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Ringing in ears, hearing loss	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○

Total ☐

Date: **Name:**

4. NOSE	Stuffy nose	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Sinus problems	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Hay fever	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Sneezing attacks	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Excessive mucus formation	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○

Total ☐

5. MOUTH/THROAT	Chronic coughing	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Gagging, frequent need to clear throat	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Sore throat, hoarseness, loss of voice	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Swollen or discolored tongue, gums, lips	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Canker sores	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○

Total ☐

6. SKIN	Acne	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Hives, rashes, dry skin	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Hair loss	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Flushing, hot flashes	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Excessive sweating	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○

Total ☐

7. HEART	Irregular or skipped heartbeat	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Rapid or pounding heartbeat	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○
	Chest pain	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○

Total ☐

Date: **Name:**

8. LUNGS	Chest congestion	0	1	2	3	4
	Asthma, bronchitis	0	1	2	3	4
	Shortness of breath	0	1	2	3	4
	Difficulty breathing	0	1	2	3	4

Total

9.DIGESTIVE TRACT	Nausea, vomiting	0	1	2	3	4
	Diarrhea	0	1	2	3	4
	Constipation	0	1	2	3	4
	Bloated feeling	0	1	2	3	4
	Belching, passing gas	0	1	2	3	4
	Heartburn	0	1	2	3	4
	Intestinal/stomach pain	0	1	2	3	4

Total

10. JOINTS/MUSCLE	Pain or aches in joint	0	1	2	3	4
	Arthritis	0	1	2	3	4
	Stiffness or limitation of movement	0	1	2	3	4
	Pain or aches in muscles	0	1	2	3	4
	Feeling of weakness or tiredness	0	1	2	3	4

Total

11. WEIGHT	Binge eating/drinking	0	1	2	3	4
	Craving certain foods	0	1	2	3	4
	Excessive weight	0	1	2	3	4
	Compulsive eating	0	1	2	3	4
	Water retention	0	1	2	3	4

Total Page 3:	Underweight	0	1	2	3	4

Date: **Name:**

12. ENERGY/ACTIVITY	Fatigue, sluggishness	**0**	**1**	**2**	**3**	**4**
	Apathy, lethargy	**0**	**1**	**2**	**3**	**4**
	Hyperactivity	**0**	**1**	**2**	**3**	**4**
	Restlessness	**0**	**1**	**2**	**3**	**4**

Total

13. MIND	Poor memory	**0**	**1**	**2**	**3**	**4**
	Confusion, poor comprehension	**0**	**1**	**2**	**3**	**4**
	Poor concentration	**0**	**1**	**2**	**3**	**4**
	Poor physical coordination	**0**	**1**	**2**	**3**	**4**
	Difficulty in making decisions	**0**	**1**	**2**	**3**	**4**
	Stuttering or stammering	**0**	**1**	**2**	**3**	**4**
	Slurred speech	**0**	**1**	**2**	**3**	**4**
	Learning disabilities	**0**	**1**	**2**	**3**	**4**

Total

14. EMOTIONS	Mood swings	**0**	**1**	**2**	**3**	**4**
	Anxiety, fear, nervousness	**0**	**1**	**2**	**3**	**4**
	Anger, irritability, aggressiveness	**0**	**1**	**2**	**3**	**4**
	Depression	**0**	**1**	**2**	**3**	**4**

Total

15. OTHER	Frequent illness	**0**	**1**	**2**	**3**	**4**
	Frequent or urgent urination	**0**	**1**	**2**	**3**	**4**
	Genital itch or discharge	**0**	**1**	**2**	**3**	**4**

Total ☐

SECTION II A to C: Risk of Exposure Date: _____Name:_____

Rate each of the following situations based upon your environmental profile for the past 12 months.

Section II.A: POINT SCALE: 0=Never, 1=Rarely, 2=Monthly, 3= Weekly, 4=Daily

_____1. How often are chemicals used in your home (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleansers)?
_____2. How often are pesticides used in your home?
_____3. How often do you have your home professionally treated for killing insects?
_____4. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in home/office.
_____5. How often are you exposed to shaving gels, shampoos, hair rinse, nail polish, perfume, hair spray, and other cosmetics?
_____6. How often are you exposed to fumes from diesel, gasoline, exhaust or machinery OR glass, chemicals, metals or any fiber(s) in the air?
_____7. How often do you swim in a pool that uses chlorine?
_____8. How often do you or your dentist use Fluoride on your teeth?
_____9. If you have metals anywhere in your body (head to foot) or amalgam, silver or mercury fillings in your teeth, score 4 for #9.

Section II.B: POINT SCALE: 0=No, 1=Mild Change, 2=Moderate Change, 3= Drastic Change

_____10. Have you noticed any negative change in your health since you moved into your house or apartment when compared to your previous home?
_____11. Have you noticed any negative change in your health since you started your current or new job?

Section II.C: POINT SCALE: 0=No and 2=Yes

_____12. Do you have a Reverse Osmosis Water Purification System in your home?
_____13. Do you have a Shower Filter?
_____14. Do you have a Air Purifier in your home?
_____15. Do you have a Air Purifier in your office or work space?
_____16. Do you have indoor pets at home or work?
_____17. Do you live on or near a farm where pesticides and/or herbicides are used on the land, either applied directly, or by airplane?
_____18. Are you a dentist, artist, painter, ceramist, mortician, mechanic, farm or construction worker, or work in a school, college or carpet store?

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PUT SUB-TOTALS Of EACH PAGE IN SPACE BELOW (Sub-Total Is The Total Score For Each Page)

_____Page 1 Sub-Total	**FOR EVALUATION OF YOUR TOXICITY QUESTIONNAIRE GRAND TOTAL SCORE**
+_____Page 2 Sub-Total	**1. Go To "Evaluation - Answers" and click on pop-out webpage titled "Toxicity Evaluation" at website address below .**
+_____Page 3 Sub-Total	**2. To open Evaluation webpage, type in the passcodes you received by email..**
+_____Page 4 Sub-Total	**PASSCODES: USER'S NAME: _____ and PASSWORD: _____ (lower case).**
+_____Page 5 Sub-Total	**Write them in blank space above for use after completing questionnaire. Call Dr. Smith at the number below to inquire about how to improve your score, i.e., internally detoxify toxic substances to improve health.**

=_____GRAND TOTAL = (Grand Total = the sum of the Sub-Totals of all five pages.)