## 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 for the past 90 days.

<table>
<thead>
<tr>
<th>Circle the corresponding number.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Rarely or Never Experience the Symptom</td>
</tr>
<tr>
<td>1</td>
<td>Occasionally Experience the Symptom, Effect is Not Severe</td>
</tr>
<tr>
<td>2</td>
<td>Occasionally Experience the Symptom, Effect is Severe</td>
</tr>
<tr>
<td>3</td>
<td>Frequently Experience the Symptom, Effect is Not Severe</td>
</tr>
<tr>
<td>4</td>
<td>Frequently Experience the Symptom, Effect is Severe</td>
</tr>
</tbody>
</table>

#### 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 and 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. 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
- e. Excessive sweating 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
- 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.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.)</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. How often are pesticides used in your home?</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. How often do you have your home treated for insects?</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office?</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics?</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total: __________________________

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

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Mild Change</th>
<th>Moderate Change</th>
<th>Drastic Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Have you noticed any negative change in your health since you moved into your home or apartment?</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Have you noticed any change in your health since you started your new job?</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total: __________________________

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Do you have a water purification system in your home?</td>
<td>2 0</td>
<td></td>
</tr>
<tr>
<td>b. Do you have any indoor pets?</td>
<td>0 2</td>
<td></td>
</tr>
<tr>
<td>c. Do you have an air purification system in your home?</td>
<td>2 0</td>
<td></td>
</tr>
<tr>
<td>d. Are you a dentist, painter, farm worker, or construction worker?</td>
<td>0 2</td>
<td></td>
</tr>
</tbody>
</table>

Total: __________________________

Section II Total: __________________________

Grand Total (Section I & Section II) __________________________

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 purification program.

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