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:	

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:	

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:	

4. ENERGY/ACTIVITY

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

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:	

6. HEAD

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

7. LUNGS

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

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:	

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:	

10. NOSE

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

11. SKIN

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

12. HEART

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

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:	

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:	

15. OTHER

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

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:	

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:	

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:		

Section II Total:	

Grand Total (Section I & II)	

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.