Toxicity Questionnaire

Name____ Date__________________

Rate each of the following symptoms experienced over the past month. Levels of toxicity: 0= never
1=Occasionally have it. 2=Occasionally have it, but it is severe. 3=Frequently have it.

Head	_____ Headaches _____ Faintness _____ Dizziness _____ Insomnia Total_________	Digestive Tract	_____ Nausea, vomiting _____ Diarrhea _____ Constipation _____ Bloating Total________
Eyes	______ Watery or itchy eyes ______ Swollen, reddened or sticky eyelids ______ Bags or dark circles under eyes ______ Blurred vision Total_________	Digestive Tract	______ Belching ______ Gas ______ Heartburn ______ Stomach pain ______ Intestinal pain Total________
Ears	_____ Itchy ears _____ Earaches, ear infections _____ Drainage from ears _____ Ringing in ears _____ Hearing loss Total_________	Joints/ Muscle	_____ Pain or aches in joints _____ Arthritis _____ Stiffness _____ Feeling of weakness _____ Pain/aches in muscles Total_______
Nose	______Stuffy nose _____ Sinus problems _____ Hay fever _____ Sneezing attacks _____ Excessive mucous formation Total_________	Weight	_____ Binge eating/drinking _____ Craving certain foods _____ Excessive weight _____ Water retention _____ Compulsive eating Total________
Mouth/ Throat	______ Chronic cough ______ Frequent need to clear throat ______ Sore throat ______ Hoarseness or loss of voice ______ Swollen or discolored tongue ______ Canker sores Total________	Energy	_____ Fatigue, sluggishness _____ Apathy, lethargy _____ Hyperactivity _____ Restlessness Total________
Skin	_____ Acne _____ Hives _____ Rashes _____ Hair loss _____ Flushing _____ Excessive sweating Total________	Mind & Emotions	_____ Poor memory _____ Confusion _____ Difficulty in making decisions _____ Stuttering or stammering _____ Slurred speech _____ Learning disabilities
Lungs	_____ Chest, congestion _____ Asthma, bronchitis _____ Shortness of breath _____ Difficulty breathing Total________		_____ Poor concentration _____ Poor physical coordination _____ Mood swings _____ Anger, irritability Total________
		Grand Total	Total________

Ability to Tolerate Chemicals

1. Are you presently using prescription medications?
   _____ Yes _____ No

   If yes, how many are you currently taking? _______

2. If you have used or are currently using prescription medications, which of the following scenarios best represents your response to them:

   _____ Experience side effects, but do best at lowered doses.
   _____ Experience side effects, but do well at usual doses.
   _____ Experience no side effects, but drugs don't usually work well for me.
   _____ Experience no side effects, and drugs usually work well for me.

3. Do you have strong negative reactions to caffeine or caffeine containing products?
   _____ Yes _____ No _____ Don't know

4. Do you commonly experience "brain fog," fatigue, or drowsiness?
   _____ Yes _____ No

5. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
   _____ Yes _____ No _____ Don't know

6. Do you feel ill after you consume even small amounts of alcohol?
   _____ Yes _____ No _____ Don't know

7. Do you have a personal history of:
   _____ Environmental and/or chemical sensitivities
   _____ Chronic fatigue syndrome
   _____ Multiple chemical sensitivity
   _____ Fibromyalgia
   _____ Parkinson's type symptoms
   _____ Alcohol or chemical dependence
   _____ Asthma

8. Do you have a history of significant exposure to harmful chemicals such as pesticides, metals, insecticides, or solvents?
   _____ Yes _____ No

9. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?
   _____ Yes _____ No _____ Don't know

10. Do you currently use or have you used tobacco products? Illicit drugs?
    _____ Yes _____ No Yes_____ _____ No