

TOXICITY QUESTIONNAIRE

The Toxicity Questionnaire is designed to aid in assessing your need for a Clinical Purification™ or Detox Program.

SECTION I: SYMPTOMS

Rate each of the following based upon your health profile for the past 90 days(3 months).

Circle the corresponding number.

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	6. HEAD	11. SKIN
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 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: _____	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: _____	a. Acne 0 1 2 3 4 b. Hives, rashes, 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: _____
2. EARS	7. LUNGS	12. HEART
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, hearing loss 0 1 2 3 4 Total: _____	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: _____	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: _____
3. EMOTIONS	8. MIND	13. JOINTS / MUSCLES
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. Apathy / lethargy 0 1 2 3 4 Total: _____	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: _____	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, limited movement 0 1 2 3 4 e. Pain, 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: _____
4. ENERGY / ACTIVITY	9. MOUTH / THROAT	14. WEIGHT
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: _____	a. Chronic coughing 0 1 2 3 4 b. Gagging, 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: _____	a. Binge eating / 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: _____
5. EYES	10. NOSE	15. OTHER
a. Watery, 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 / tunnel vision 0 1 2 3 4 Total: _____	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: _____	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: _____ (Add all totals for section I only)

SECTION II: RISK OF EXPOSURE

Rate each of the following situations based upon your environment profile for the past 120 days (4 months).

16. Circle the corresponding number for questions 16a - 16f below.
0= Never 1= Rarely 2= Monthly 3= Weekly 4= Daily

16a. 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
16b. How often are pesticides used in your home?	0	1	2	3	4
16c. How often do you have your home treated for insects?	0	1	2	3	4
16d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, incense, or varnish in your home or office?	0	1	2	3	4
16e. How often are you exposed to nail polish, perfume, hair spray and other cosmetics?	0	1	2	3	4
16f. 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 change 3= Drastic change

17a. Have you noticed any negative change in your health since you moved into your home or apartment?	0	1	2	3
17b. Have you noticed any negative 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.

	NO	YES
18a. Do you have a water purification system in your home?	2	0
18b. Do you have any indoor pets?	0	2
18c. Do you have an air purification system in your home?	2	0
18d. Are you a dentist, painter, farm worker or construction worker?	0	2
	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 Clinical Purification™ program.

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

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