

# Toxicity Assessment

The Toxicity Assessment is designed to aid the practitioner in assessing the patient's need for a Detoxification Program.

## SECTION I: SYMPTOMS

Rate each of the following based upon your health profile for the last 90 days.

Use this guide to circle the number of your answer to the following questions:

0 = Never

1 = Rarely

2 = Not severe (Occasionally experience)

3 = Is severe (Often experience)

4 = Very severe (Frequently experience)

### 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
TOTAL= _____					

### 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. Difficulty making decisions	0	1	2	3	4
E. Stuttering, stammering	0	1	2	3	4
F. Slurred speech	0	1	2	3	4
G. Learning disability	0	1	2	3	4
H. Poor coordination	0	1	2	3	4
TOTAL=					

### EYES

A. Watery, itchy eyes	0	1	2	3	4
B. Swollen, reddened	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= _____					

### EARS

A. Itchy Ears	0	1	2	3	4
B. Ear Aches / 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=					

### 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=					

### MOUTH / THROAT

A. Chronic coughing	0	1	2	3	4
B. Gagging, need to clear throat	0	1	2	3	4
C. Swollen or discolored tongue, gums or lips	0	1	2	3	4
TOTAL=					

### 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 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= _____					
<b>LUNGS</b>					
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= _____					
<b>HEART</b>					
A. Skipped heartbeats	0	1	2	3	4
B. Rapid heartbeats	0	1	2	3	4
C. Chest pains	0	1	2	3	4
TOTAL= _____					
<b>BOWELS / OTHER</b>					
A. Frequent or urgent urination	0	1	2	3	4
B. Leaky bladder	0	1	2	3	4
C. Frequent illness	0	1	2	3	4
TOTAL= _____					
<b>SKIN</b>					
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= _____					
<b>JOINTS / MUSCLE</b>					
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 muscle	0	1	2	3	4
F. Frequent back pain	0	1	2	3	4
G. Feeling of weakness or tiredness	0	1	2	3	4
TOTAL= _____					
<b>WEIGHT</b>					
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. Under weight	0	1	2	3	4
TOTAL= _____					
<b>EMOTIONS</b>					
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. Lethargy	0	1	2	3	4
TOTAL= _____					
<b>ENERGY</b>					
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= _____

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**SECTION I TOTALS** \_\_\_\_\_

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**SECTION II: RISK OF EXPOSURE**

Rate each of the following based upon your health profile for the last 120 days.

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**Circle the corresponding number for the following questions**

0 = Never	1 = Rarely	2 = Monthly	3 = Weekly	4 = Daily
A. How often are strong chemicals used in your home? <i>(Disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.)</i>				
				0 1 2 3 4
B. How often are pesticides used in your home?				
				0 1 2 3 4
C. How often do you have your home treated for insects?				
				0 1 2 3 4
D. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office?				
				0 1 2 3 4
E. How often are you exposed to nail polish, perfume, hair spray, and other cosmetics?				
				0 1 2 3 4
F. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?				
				0 1 2 3 4
TOTAL= _____				

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**Answer Yes or No and circle the corresponding number for the following questions**

	Y	N
A. Do you have a water purification system in your home?	0	2
B. Are pesticides used frequently in your home?	2	0
C. Do you have an air purification system in your home?	0	2
D. Are you a dentist, painter, farm worker or construction worker?	2	0
TOTAL= _____		

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**SECTION II TOTALS** \_\_\_\_\_

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<b>SECTION I TOTAL =</b>	_____
<b>SECTION II TOTAL =</b>	_____
<b>GRAND TOTAL =</b>	_____

Add up the numbers to arrive at a total for each section, and then add the totals of BOTH sections together to arrive at GRAND TOTAL. If any individual section is 6 or more, or GRAND TOTAL is 40 or more, you may benefit from a Detox program.