TOXICITY QUESTIONNAIRE

Section I: Symptoms

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

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**					
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.	Bloated 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.	Earaches or 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 dispair	0	1	2	3	4
f.	Uncaring or disinterest	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
	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.	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 difficulties	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, 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	**JOINT/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.	Reccurent 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 environment profile for the past 120 days.

16 **Circle the corresponding number for questions 16a-16f below.**

0 Never 1 Rarely 2 Monthly 3 Weekly 4 Daily

a.	How often are strong chemicals used in your home?	0	1	2	3	4
	(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc)					
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, or other cosemetics?	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 ____________

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

0 No 1 Mild Change 2 Moderate Change 3 Drastic Change

a.	Have you noticed any negative change in your health since you moved into your home or apartment?	0	1	2	3
b.	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
a.	Do you have a water purification system in your home?	2	0
b.	Do you have any indoor pets?	0	2
c.	Do you have an air purification system in your home?	2	0
d.	Are you a dentist, painter, farm worker, or construction worker?	0	2

Total ____________

Section II Total ____________

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

Please fax your results to 212-399-9659, or mail it to 200 W 57 St. Ste 1010 NY, NY, 10019
A no cost consultation with the doctor will be set up after receiving and interpreting your results. Please provide your phone number, your e-mail address, and the best time to contact you when submitting.
Thank you,
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