Name: _____

3-Step Detoxification Symptom Questionnaire

Date: _____

Rate each of the following symptoms based upon your typical health profile:

0 - Never almost never have the symptoms
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

Digestive

	Nausea or vomiting
	Diarrhea
	Constipation
	Bloated feeling
	Belching, passing gas
	Heartburn
	Total Score

Emotions

	Mood Swings
	Anxiety, fear, nervous
	Anger, irritability
	Depression
	Total Score

Eyes

	Watery, itchy eyes
	Swollen, reddened, sticky eyelids
	Dark circles under eyes
	Blurred, tunnel vision
	Total Score

Lungs

	Chest congestion
	Asthma, bronchitis
	Shortness of breath
	Difficulty breathing
	Total Score

Mind

	Poor Memory
	Confusion
	Poor concentration
	Poor coordination
	Difficulty making decisions
	Stuttering, stammering
	Slurred speech
	Learning disabilities
	Total Score

	GRAND TOTAL

Energy/Activity

	Fatigue, sluggishness
	Apathy
	Hyperactivity
	Restlessness
	Total Score

Head

	Headaches
	Faintness
	Dizziness
	Insomnia
	Total Score

Ears

	Itchy ears
	Earaches, ear infections
	Drainage from ears
	Ringing in ears, hearing loss
	Total Score

Mouth/Throat

	Chronic coughing
	Gagging, needing to clear throat
	Sore throat, hoarse
	Swollen or discolored tongue, gums or lips
	Canker sores
	Total Score

Skin

	Acne
	Hives, rashes, dry skin
	Hair loss
	Flushing, hot flashes
	Excessive sweating
	Total Score

Joints/Muscles

	Pain or aches in joints
	Arthritis
	Stiff, limited movement
	Pain, aches in muscles
	Weakness or tiredness
	Total Score

Nose

	Stuffy Bose
	Sinus problems
	Hay fever, allergies
	Sneezing attacks
	Excessive mucus
	Total Score

Heart

	Skipped heartbeats
	Rapid heartbeats
	Chest pain
	Total Score

Weight

	Binge eating/drinking
	Craving certain foods
	Excessive weight gain
	Compulsive eating
	Water retention
	Underweight
	Total Score

Other

	Frequent illness
	Frequent, urgent urination
	Genital itch, discharge
	Total Score

Add up the numbers to arrive at a total for each section, then add the totals for each section to arrive at the grand total. If any individual section total is 10 or more, or the grand total is 14 or more, you may benefit from a 3-Step detoxification program.

Pain & Toxicity Assessment

Mark the symptoms you experience:

Yes	No	
❍	❍	Do you feel tired or fatigued?
❍	❍	Do you experience early morning stiffness?
❍	❍	Do you feel stiff after periods of rest?
❍	❍	Do you feel dizzy, foggy-headed or have trouble concentrating?
❍	❍	Do you experience cracking joints?
❍	❍	Do you experience frequent back pain or headaches?
❍	❍	Do you ear fast, fatty, processed or fried foods?
❍	❍	Do you experience generalized aches and pains in the body?
❍	❍	Do you experience frequent sinus problems?
❍	❍	Do you use coffee, cigarettes, candy or soda to get "up"?
❍	❍	Are you sleepy in the afternoon?
❍	❍	Do you experience intestinal gas and bloating after meals?
❍	❍	Do you bruise easily?
❍	❍	Do you recover slowly from moderate exercise?
❍	❍	Do you feel you don’t exercise enough or feel sluggish and need to lose weight?
❍	❍	Do you have food allergies, or are often exposed to chemicals,. Sedatives or stimulants?
❍	❍	Do you take pain relievers to get rid of aches and pains?
❍	❍	Do you have a family history of arthritis or auto-immune disorders?
❍	❍	Do your bowels move less than twice per day?
❍	❍	Do you "air our" your office and bedroom a few minutes every day?
❍	❍	Do you have a shower filter?
❍	❍	Do you mostly eat organic fresh foods?
❍	❍	I have not installed a new filter in my heating/air conditioning unit in the past 6 months.
❍	❍	I have not done a cleansing program recently.

_____ **Total number of symptoms you experience**

If your Yes score totals 4 or greater, your current symptoms might be due to toxic overload and may suggest you need a 3-Step detoxification program to purify your system of toxins and experience **PAIN FREE** living.