

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Toxicity Questionnaire

This questionnaire will help Dr. Seamus Allen determine your need for a detoxification program.

Circle or Bold 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

**Section I: Symptoms**

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

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 &/or passing gas 0 1 2 3 4

f. Heartburn 0 1 2 3 4

 Total: \_\_\_\_\_\_\_

1. 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/hearing loss 0 1 2 3 4

 Total: \_\_\_\_\_\_\_

1. 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 despair 0 1 2 3 4

f. Uncaring or disinterested 0 1 2 3 4

 Total: \_\_\_\_\_\_\_

1. 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: \_\_\_\_\_\_\_

1. 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: \_\_\_\_\_\_\_

1. HEAD

a. Headaches 0 1 2 3 4

b. Dizziness 0 1 2 3 4

c. Faintness 0 1 2 3 4

d. Pressure 0 1 2 3 4

 Total: \_\_\_\_\_\_\_

1. 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: \_\_\_\_\_\_\_

1. 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. 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: \_\_\_\_\_\_\_

1. 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: \_\_\_\_\_\_\_

1. 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 mucus 0 1 2 3 4

 Total: \_\_\_\_\_\_\_

1. SKIN

 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: \_\_\_\_\_\_\_

1. 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: \_\_\_\_\_\_\_

1. JOINTS/MUSCLES

 a. Pain or aches in joints 0 1 2 3 4

 b. Stiffness or limited movement 0 1 2 3 4

 c. Pain or aches in muscles 0 1 2 3 4

 d. Recurrent back aches 0 1 2 3 4

 e. Feeling of weakness or tiredness 0 1 2 3 4

 Total: \_\_\_\_\_\_\_

1. 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: \_\_\_\_\_\_\_

1. OTHER
2. Frequent illness 0 1 2 3 4
3. Frequent or urgent urination 0 1 2 3 4
4. Leaky bladder 0 1 2 3 4
5. Genital itch, discharge 0 1 2 3 4

 Total: \_\_\_\_\_\_\_

SECTION 1 TOTAL = \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2: Risk of Exposure**

Rate each of the following situations based upon your environmental profile for the past 120 days.

Circle or Bold the Corresponding Number:

0 = Never

1 = Rarely

2 = Monthly

3 = Weekly

4 = Daily

16:

1. 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

1. How often are pesticides used in your home?

0 1 2 3 4

1. How often do you have your home treated for insects?

0 1 2 3 4

1. 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 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

g. How often do you consume non-organic foods?

 0 1 2 3 4

 Total: \_\_\_\_\_\_

Circle or bold the corresponding number:

0 = No

1 = Mild change

2 = Moderate change

3 = Drastic change

17:

1. Have you noticed any negative change in your health since you moved into your home or apartment?

 0 1 2 3

1. Have you noticed any change in your health since you started your new job?

 0 1 2 3

 Total: \_\_\_\_\_\_

Answer yes or no and circle or bold the corresponding number:

 No Yes

18:

1. Do you have a water purification system

in your home? 2 0

b. Do you have indoor pets? 0 2

1. Do you have an air purification system

in your home? 2 0

1. Are you a dentist, painter, farm worker

or construction worker? 0 2

 Total: \_\_\_\_\_\_

SECTION 2 TOTAL = \_\_\_\_\_\_\_\_\_\_\_\_\_\_

GRAND TOTAL (SECTION 1 + SECTION 2) = \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Add up the numbers to arrive at a total for each section, and then add up 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 detoxification program.