



# Toxicity Questionnaire

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# Toxicity Questionnaire: Section 1 - Symptoms

## Section 1 - Symptoms

This toxicity questionnaire is designed to assess your needs for a detoxifying program, make you more aware of what decides on your toxicity levels and check the results after completion of your detox program.

Rate each of the following based on your typical health profile within the past 90-days, and circle the corresponding number, then calculate your grand total.

### Point Scale:

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

HEAD	Headaches	0	1	2	3	4
	Faintness	0	1	2	3	4
	Dizziness	0	1	2	3	4
	Insomnia	0	1	2	3	4
EYES	Watery or itchy eyes	0	1	2	3	4
	Swollen, reddened or sticky eyelids	0	1	2	3	4
	Bags or dark circles under eyes	0	1	2	3	4
	Blurred or tunnel vision	0	1	2	3	4
LUNGS	Chest congestion	0	1	2	3	4
	Asthma, bronchitis	0	1	2	3	4
	Shortness of breath	0	1	2	3	4
	Difficulty breathing	0	1	2	3	4
DIGESTIVE	Nausea and/or vomiting	0	1	2	3	4
	Diarrhea	0	1	2	3	4
	Constipation	0	1	2	3	4
	Bloated feeling	0	1	2	3	4
	Blenching and/or passing gas	0	1	2	3	4
	Heartburn	0	1	2	3	4
	Intestinal/stomach pain	0	1	2	3	4

# Toxicity Questionnaire: Section 1 - Symptoms

MOUTH & THROAT	Chronic coughing	0	1	2	3	4
	Gagging, frequent need to clear throat	0	1	2	3	4
	Sore throat, hoarseness, loss of voice	0	1	2	3	4
	Swollen or discoloured tongue, gums, lips	0	1	2	3	4
	Canker sores	0	1	2	3	4
NOSE	Stuffy nose	0	1	2	3	4
	Sinus problems	0	1	2	3	4
	Hay fever	0	1	2	3	4
	Sneezing attacks	0	1	2	3	4
	Excessive mucus	0	1	2	3	4
EARS	Itchy ears	0	1	2	3	4
	Earaches, ear infections	0	1	2	3	4
	Drainage from ear	0	1	2	3	4
	Ringing in ears, hearing loss	0	1	2	3	4
SKIN	Acne	0	1	2	3	4
	Hives, rashes, dry skin	0	1	2	3	4
	Hair loss	0	1	2	3	4
	Flushing, hot flushes	0	1	2	3	4
	Excessive sweating	0	1	2	3	4
HEART	Irregular or skipped heartbeat	0	1	2	3	4
	Rapid or pounding heartbeat	0	1	2	3	4
	Chest pain	0	1	2	3	4
WEIGHT	Binge eating or drinking	0	1	2	3	4
	Craving certain foods	0	1	2	3	4
	Excessive weight	0	1	2	3	4
	Compulsive eating	0	1	2	3	4
	Water retention	0	1	2	3	4
	Underweight	0	1	2	3	4

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EMOTIONS	Mood swings	0	1	2	3	4
	Anxiety, fear, nervousness	0	1	2	3	4
	Anger, irritability, aggressiveness	0	1	2	3	4
	Depression	0	1	2	3	4
MIND	Poor memory	0	1	2	3	4
	Confusion, poor comprehension	0	1	2	3	4
	Poor concentration	0	1	2	3	4
	Poor physical coordination	0	1	2	3	4
	Difficulty in making decisions	0	1	2	3	4
	Stuttering, stammering	0	1	2	3	4
	Slurred speech	0	1	2	3	4
	Learning disabilities	0	1	2	3	4
JOINT & MUSCLES	Pain or aches in joints	0	1	2	3	4
	Arthritis	0	1	2	3	4
	Stiffness or limitation of movement	0	1	2	3	4
	Pain or aches in muscles	0	1	2	3	4
	Feeling of weakness or tiredness	0	1	2	3	4
ENERGY & ACTIVITY	Frequent illness	0	1	2	3	4
	Frequent or urgent urination	0	1	2	3	4
	Genital itch or discharge	0	1	2	3	4
OTHER	Fatigue, sluggishness	0	1	2	3	4
	Hyperactivity	0	1	2	3	4
	Apathy, lethargy	0	1	2	3	4
	Restlessness	0	1	2	3	4

SECTION 1 - SYMPTOMS TOTAL SCORE:

# Toxicity Questionnaire: Section 2 - Risk of Exposure

## Section 2 - Risk of Exposure

### PART A:

#### Point Scale:

- 0 - Never
- 1 - Rarely
- 2 - Monthly
- 3 - Weekly
- 4 - Daily

How often are strong chemicals used at your home? (bleaches, drain cleaners, floor wax, window cleaners, etc.)	0	1	2	3	4
How often are pesticides used in your home?	0	1	2	3	4
How often do you have your home treated for insects?	0	1	2	3	4
How often are you exposed to dust, overstuffed furniture, tabaco smoke, mothballs, incense, or varnish in your home?	0	1	2	3	4
How often are you exposed to nail polish, perfume, hairspray, or other cosmetics?	0	1	2	3	4
How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?	0	1	2	3	4

### PART B:

#### Point Scale:

- 0 - No
- 1 - Mild Change
- 2 - Moderate change
- 3 - Drastic change

Have you noticed any negative change in your health since you moved into your home or apartment?	0	1	2	3
Have you noticed any change in your health since you started your new job?	0	1	2	3

### PART C:

#### Point Scale:

- Answer Yes or No

Do you have a water purification in your home?		
Do you have indoor pets?		
Do you have any air purification system in your home?		
Are you a dentist, farmer or construction worker?		
Do you wash your produce?		
Do you smoke?		
Do you have amalgam fillings or caps?		

SECTION 2 - SCORE:

SECTION 1 & 2 TOTAL SCORE:

Add up the numbers from both section 1 and 2, and note your grand totals. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a detox program.