Detox Questionnaire

The Detox Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a Clinical Purification™ program.

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, 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:_____

3. EMOTIONS	
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. Apathy/Lethargy	0 1 2 3 4

Total:_____

4. ENERGY/ACTIVITY	
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:_____

5. EYES	
A. Watery, Itchy Eyes	0 1 2 3 4
B. Swollen, Reddened or Sticky Eyelids	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:_____

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, 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. 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:_____

9. MOUTH/THROAT	
A Chronic Coughing	0 1 2 3 4
B. Gagging, 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. JOINTS/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, Limited Movement	0 1 2 3 4
E. Pain, Aches in Muscles	0 1 2 3 4
F. Recurrent Back Aches	0 1 2 3 4
G. Feeling of Tiredness/ Weakness	0 1 2 3 4

Total:_____

14. WEIGHT	
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. 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 environmental 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? (Disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.)										0 1 2 3 4
B. How often are strong 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 exposed to dust, overstuffed furniture, Tobacco smoke, mothballs, incense, or varnish in your home?										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:_____

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 changes in your health since you moved into your home or apartment?								0 1 2 3
B. Have you noticed any negative changes 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 – 17D 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: _____

GRAND TOTAL (Section I + Section II) _____

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