TOXICITY QUESTIONNAIRE

PURIFY 2.0

Name: _____ Date: _____

The Toxicity Screening Questionnaire helps you track your progress over time. If this is your first time taking the questionnaire, rate each of the following based upon your health profile for the past 30 days. If this is not your first time taking the questionnaire, mark your results for the past 48 hours only.

Point Scale:
0 = Never or almost never have this situation
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
___ Upset stomach
___ Loose stool
___ Difficulty with bowel movement
___ Bloated feeling
___ Chest or gut discomfort after eating
___ Intestinal/stomach discomfort

Ears
___ Itchy ears
___ Difficulty sorting out ambient noise, tinnitus

Emotions
___ Moodiness
___ Feelings of anxiousness or nervousness
___ Anger, easily irritated or aggressive
___ Feeling blue/melancholy

Energy/Activity
___ Fatigue, sluggishness
___ Feelings of indifference
___ Feelings of restlessness

Eyes
___ Excess tears in eyes
___ Frequent rubbing of eyes
___ Change of appearance in eyelids; harder to open
___ Bags or dark circles under eyes

Head
___ Pressure or discomfort in the head
___ Feeling dizzy
___ Loss of balance during or after movement
___ Sleeplessness

Heart
___ Heartbeat rhythm concerns
___ Discomfort in the chest

Joints/Muscles
___ Joint discomfort
___ Stiffness, lack of free movement
___ Muscle soreness
___ Feeling weak

Lungs
___ Coughing
___ Respiratory concerns
___ Difficult breathing

Mind
___ Memory concerns
___ Reduced concentration
___ Won't or can't make decisions

Mouth/Throat
___ Frequent coughing
___ Frequent need to clear throat
___ Mouth discomfort eating acidic foods

Nose
___ Stuffy nose
___ Head congestion
___ Seasonal respiratory irritation
___ Sneezing
___ Too much mucus

Skin
___ Facial blemishes
___ Red bumps or patches
___ Thinning hair
___ Flushing in the face
___ Excessive sweating

Weight
___ Binge eating/drinking
___ Craving certain foods
___ Being overweight
___ Compulsive eating
___ Water retention

Other
___ Feel the need to urinate often
___ Frequent urination
___ Genital irritation

TOTAL _____

Disclaimer: This assessment is not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. Consult your health care provider about questions you may have.

*If you marked a 3 or 4 on one or more of the above, you should consult your health care provider.

Key to Questionnaire
Add individual scores and total each group. Add group scores for a grand total.

Less than 10	**Low Toxicity**
10-50	**Mild Toxicity**
50-100	**Moderate toxicity**
Over 100	**High toxicity***

*You should discuss these results with your doctor.