

Toxicity and Inflammation Questionnaire

NAME _____

DATE _____

WEEK _____

Rate each of the following symptoms based upon your typical health profile for: *Past 30 days*

| | | |
|--------------------|--|--|
| Point Scale | 0 <i>Never or almost never</i> have the symptom | 3 <i>Frequently</i> have it, effect is <i>not severe</i> |
| | 1 <i>Occasionally</i> have it, effect is <i>not severe</i> | 4 <i>Frequently</i> have it, effect is <i>severe</i> |
| | 2 <i>Occasionally</i> have it, effect is <i>severe</i> | |

0-10 optimal 10-50- mild toxicity 50-100 moderate toxicity >100 severe toxicity

HEAD

_____ Headaches

_____ Faintness

_____ Dizziness

_____ Insomnia

_____ TOTAL

EYES

_____ Watery or itchy eyes

_____ Swollen, reddened or sticky eyelids

_____ Bags or dark circles under eyes

_____ Blurred or tunnel vision (does not include near- or far-sightedness)

_____ TOTAL

EARS

_____ Itchy ears

_____ Earaches, ear infections

_____ Drainage from ear

_____ Ringing in ears, hearing loss

_____ TOTAL

NOSE

_____ Stuffy nose

_____ Sinus problems

_____ Hay fever

_____ Sneezing attacks

_____ Excessive mucus formation

_____ TOTAL

MOUTH/ THROAT

_____ Chronic coughing

_____ Gagging, frequent need to clear throat

_____ Sore throat, hoarseness, loss of voice

_____ Swollen or discolored tongue, gums or lips

_____ Canker sores

_____ TOTAL

SKIN

_____ Acne

_____ Hives, rashes, dry skin

_____ Hair loss

_____ Flushing, hot flashes

_____ Excessive sweating

_____ TOTAL

HEART

_____ Irregular or skipped heartbeat

_____ Rapid or pounding heartbeat

_____ Chest pain

_____ TOTAL

LUNGS

_____ Chest congestion

_____ Asthma, bronchitis

_____ Shortness of breath

_____ Difficulty breathing

_____ TOTAL

DIGESTIVE TRACT

_____ Nausea, vomiting

_____ Diarrhea

_____ Constipation

_____ Bloating feeling

_____ Belching, passing gas

_____ Heartburn

_____ Intestinal/stomach pain

_____ TOTAL

JOINTS/ MUSCLE

_____ Pain or aches in joints

_____ Arthritis

_____ Stiffness or limitation of movement

_____ Pain or aches in muscles

_____ Feeling of weakness or tiredness

_____ TOTAL

WEIGHT

_____ Binge eating/drinking

_____ Craving certain foods

_____ Excessive weight

_____ Compulsive eating

_____ Water retention

_____ Underweight

_____ TOTAL

ENERGY/ ACTIVITY

_____ Fatigue, sluggishness

_____ Apathy, lethargy

_____ Hyperactivity

_____ Restlessness

_____ TOTAL

MIND

_____ Poor memory

_____ Confusion, poor comprehension

_____ Poor concentration

_____ Poor physical coordination

_____ Difficulty in making decisions

_____ Stuttering or stammering

_____ Slurred speech

_____ Learning disabilities

_____ TOTAL

EMOTIONS

_____ Mood swings

_____ Anxiety, fear, nervousness

_____ Anger, irritability, aggressiveness

_____ Depression

_____ TOTAL

OTHER

_____ Frequent illness

_____ Frequent or urgent urination

_____ Genital itch or discharge

_____ TOTAL

GRAND TOTAL _____

