

# Do I Need to Detox?

## TOXIC SYMPTOMS SURVEY

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Based on how you've been feeling over the past 30 days, please rate the signs and symptoms using the numbers on the key below to help assess toxic burden and detoxification needs.

**KEY:**  
 0/Leave blank = No, never occurs      2 = Occasionally occurs, effect is mild      4 = Frequently occurs, effect is severe  
 1 = Almost never, effect is mild      3 = Frequently occurs, effect is not severe      5 = Very frequent, constant, effect is severe

### GASTROINTESTINAL

- Belching or gas
- Heartburn or acid reflux
- Bloating or abdominal discomfort shortly after eating
- Bad breath (halitosis)
- Aggravated by certain foods
- Diarrhea, chronic
- Undigested food in stool
- Constipation
- Nausea or vomiting
- Fewer than one bowel movement a day
- Stools are loose and unformed
- TOTAL**

### LIVER

- Easily intoxicated if drinking alcohol
- Hangovers after drinking alcohol
- Sensitive to chemicals (perfume, solvents, exhaust)
- Sensitive to tobacco smoke
- Hemorrhoids or varicose veins
- Chronic fatigue or chronic joint pain
- Feeling wired or jittery if drinking coffee
- Feet have a strong odor
- Sweat has a strong odor
- TOTAL**

### EYES

- Dark circles around the eyes
- Puffy eyelids
- Bags under the eyes
- Bloodshot or reddened eyes
- Whites of eyes are yellowed
- Eyes are water and/or itchy
- Blurred or tunnel vision
- TOTAL**

### SKIN

- Experience hives, cysts, boils, rashes
- Cold sores, fever blisters, or herpes lesions
- Dry flaky skin and/or dandruff
- Fragile skin, easily chaffed, as in shaving.
- Acne
- Itchy skin / dermatitis
- Dull colored skin, yellowish, pale or grayish
- Skin has a sour or unpleasant odor
- TOTAL**

### NAILS

- Ridged nails
- Splitting nails
- White spots on nails
- Crumbling nails
- TOTAL**

### EAR, NOSE, THROAT

- Ear infections
- Itchy ears
- Ringing in the ears
- Stuffy nose
- Sinus congestion, "stuffy head", sinus infections
- Runny or drippy nose
- Coated tongue (yellow, grayish-white or thick film)
- Swollen tongue
- Hoarseness
- Lump in throat
- Dry mouth, eyes and / or nose
- Gag easily or need to clear throat often
- Mouth ulcers or canker sores
- TOTAL**

**HEAD**

- \_\_\_\_\_ Tension headaches at base of skull
- \_\_\_\_\_ Splitting type headache
- \_\_\_\_\_ Dizziness
- \_\_\_\_\_ Faintness
- \_\_\_\_\_ **TOTAL**

**HEART/LUNGS**

- \_\_\_\_\_ Asthma
- \_\_\_\_\_ Wheezing or difficulty breathing
- \_\_\_\_\_ Shortness of breath
- \_\_\_\_\_ Chest congestion
- \_\_\_\_\_ Heart races, rapid heartbeat
- \_\_\_\_\_ Fast pulse at rest
- \_\_\_\_\_ Flush or blush easily or face turns red for no reason
- \_\_\_\_\_ **TOTAL**

**MENTAL EMOTIONAL**

- \_\_\_\_\_ Feel 'foggy', thinking seems slow or fuzzy
- \_\_\_\_\_ Bizarre vivid or nightmarish dreams
- \_\_\_\_\_ Depressed
- \_\_\_\_\_ Worried, apprehensive, anxious
- \_\_\_\_\_ Nervous or agitated
- \_\_\_\_\_ Mentally sluggish, difficulty concentrating
- \_\_\_\_\_ Mood swings
- \_\_\_\_\_ Coordination is poor
- \_\_\_\_\_ Poor memory
- \_\_\_\_\_ **TOTAL**

**MUSCULOSKELETAL**

- \_\_\_\_\_ Pain or swelling in joints
- \_\_\_\_\_ Muscles become easily fatigued
- \_\_\_\_\_ Muscle aches and pains
- \_\_\_\_\_ Arthritic tendencies
- \_\_\_\_\_ Joint pain after mild exertion
- \_\_\_\_\_ Joint pain experienced after eating certain foods
- \_\_\_\_\_ Abdomen tends to hang out
- \_\_\_\_\_ Surface of abdomen is uneven and distended
- \_\_\_\_\_ Use over-the-counter pain medications
- \_\_\_\_\_ **TOTAL**

**ENERGY LEVELS**

- \_\_\_\_\_ Weakness
- \_\_\_\_\_ Easily fatigued, sleepy during the day
- \_\_\_\_\_ Fatigue is persistent and extreme
- \_\_\_\_\_ Apathetic and lethargic
- \_\_\_\_\_ Tired, despite a good night of rest
- \_\_\_\_\_ **TOTAL**

**WEIGHT**

- \_\_\_\_\_ Crave simple carbohydrates like bread or noodles
- \_\_\_\_\_ Crave certain foods
- \_\_\_\_\_ Retaining water
- \_\_\_\_\_ Excessive weight
- \_\_\_\_\_ **TOTAL**

**KIDNEY**

- \_\_\_\_\_ Urine has a strong odor
- \_\_\_\_\_ Pain in mid back region
- \_\_\_\_\_ Urine is frothy
- \_\_\_\_\_ Urinate infrequently
- \_\_\_\_\_ **TOTAL**

**IMMUNE SYSTEM**

- \_\_\_\_\_ Frequent infections (bladder, skin, ear, chest, sinus)
- \_\_\_\_\_ Frequent colds or flu
- \_\_\_\_\_ **TOTAL**

**METABOLISM**

- \_\_\_\_\_ Pulse speeds after eating
- \_\_\_\_\_ Night sweats
- \_\_\_\_\_ Mood swings associated with periods (PMS)
- \_\_\_\_\_ Breast tenderness associated with cycle
- \_\_\_\_\_ **TOTAL**

Please add the numbers from each section and write the total in the spaces provided. Then add all the totals from each section to get your grand total below.

\_\_\_\_\_ **GRAND TOTAL**

**60 or Below:** Low toxic burden. Congratulations! Your body is handling toxins like a champ.

**61-90:** Low to moderate toxic burden. You may benefit from a basic detoxification protocol. Your body is starting to show signs of toxic burden.

**91-113:** Moderate to high toxic burden. Time to take action. A focused detoxification program will help you get back on track.

**114 and above:** High toxic burden. Time for an advanced detoxification program. Consider detoxing your environment and committing to a minimum of two detoxes per year to get you on your way.

# Understanding Your Toxin Exposure and Detox Capabilities

## TOXIC SYMPTOMS SURVEY

- YES NO** Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, organic solvents, or toxic metals?
- YES NO** Have you ever lived near any heavy industries that regularly emitted waste into the air or water (i.e., golf course, dry cleaner, plant, shipyard, mine, chemical factory, dumpsite, or landfill)?
- YES NO** Have you even lived in a house built before 1978?
- YES NO** Have you ever lived on or adjacent to an agricultural area?
- YES NO** Have you ever lived in a home where mold was a problem?
- YES NO** Have you even lived in a home with a water leak or water damage?
- YES NO** Are pesticides or herbicides used inside or outside your home?
- YES NO** Have you ever felt there were conditions in your home that affected your health (use of aerosol sprays, chemicals, cleansers, construction, painting, etc.)?
- YES NO** Do you currently use - or within the last 6 months have you regularly used - tobacco products?
- YES NO** Do you feel ill after you consume even small amounts of alcohol?
- YES NO** Have you often had to lower the regular dose of prescription, over-the-counter medication or herbal supplements because you were too sensitive to normal doses?
- YES NO** Do you avoid caffeine in the afternoon or all together because it can keep you up at night?
- YES NO** Do you develop symptoms on exposure fragrances, exhaust fumes, or strong odors?