

Toxicity Self Test

Rate each of the following symptoms based upon your health profile for the past 30 days:

POINT SCALE:

- 0 = **NEVER OR ALMOST NEVER** have the symptom
- 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 SYSTEM <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Belching, passing gas <input type="checkbox"/> Bloating feeling <input type="checkbox"/> Heartburn <input type="checkbox"/> TOTAL	HEART <input type="checkbox"/> Skipped heartbeats <input type="checkbox"/> Rapid heartbeats <input type="checkbox"/> Chest pain <input type="checkbox"/> TOTAL
EARS <input type="checkbox"/> Itchy ears <input type="checkbox"/> Earaches, ear infection <input type="checkbox"/> Drainage from ear <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Hearing loss <input type="checkbox"/> TOTAL	JOINTS / MUSCLES <input type="checkbox"/> Pain or aches in joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Stiffness, limited movement <input type="checkbox"/> Pain, aches in muscles <input type="checkbox"/> Feeling of weakness or tiredness <input type="checkbox"/> TOTAL
EMOTIONS <input type="checkbox"/> Mood swings <input type="checkbox"/> Anxiety, fear, nervousness <input type="checkbox"/> Anger, irritability <input type="checkbox"/> Depression <input type="checkbox"/> TOTAL	LUNGS <input type="checkbox"/> Chest congestion <input type="checkbox"/> Asthma, bronchitis <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> TOTAL
ENERGY / ACTIVITY <input type="checkbox"/> Fatigue, sluggishness <input type="checkbox"/> Apathy, lethargy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Restlessness <input type="checkbox"/> TOTAL	MIND <input type="checkbox"/> Poor memory <input type="checkbox"/> Confusion <input type="checkbox"/> Poor concentration <input type="checkbox"/> Poor coordination <input type="checkbox"/> Difficulty making decisions <input type="checkbox"/> Stuttering, stammering <input type="checkbox"/> Slurred speech <input type="checkbox"/> Learning disabilities <input type="checkbox"/> TOTAL
EYES <input type="checkbox"/> Watery, itchy eyes <input type="checkbox"/> Swollen, reddened, or sticky eyelids <input type="checkbox"/> Dark circles under eyes <input type="checkbox"/> Blurred/tunnel vision <input type="checkbox"/> TOTAL	MOUTH / THROAT <input type="checkbox"/> Chronic coughing <input type="checkbox"/> Gagging, frequent need to clear throat <input type="checkbox"/> Sore throat, hoarse <input type="checkbox"/> Swollen or discolored tongue, gums, lips <input type="checkbox"/> Canker sores <input type="checkbox"/> TOTAL
HEAD <input type="checkbox"/> Headaches <input type="checkbox"/> Faintness <input type="checkbox"/> Dizziness <input type="checkbox"/> Insomnia <input type="checkbox"/> TOTAL	
NOSE <input type="checkbox"/> Stuffy nose <input type="checkbox"/> Sinus problem <input type="checkbox"/> Hay fever <input type="checkbox"/> Sneezing attacks <input type="checkbox"/> Excessive mucus <input type="checkbox"/> TOTAL	WEIGHT <input type="checkbox"/> Binge eating/drinking <input type="checkbox"/> Craving certain foods <input type="checkbox"/> Excessive weight <input type="checkbox"/> Compulsive eating <input type="checkbox"/> Water retention <input type="checkbox"/> Underweight <input type="checkbox"/> TOTAL
SKIN <input type="checkbox"/> Acne <input type="checkbox"/> Hives, rashes, dry skin <input type="checkbox"/> Hair loss <input type="checkbox"/> Flushing or hot flashes <input type="checkbox"/> Excessive sweating <input type="checkbox"/> TOTAL	OTHER <input type="checkbox"/> Frequent illness <input type="checkbox"/> Frequent or urgent need to urinate <input type="checkbox"/> Genital itch, discharge <input type="checkbox"/> TOTAL

_____ GRAND TOTAL

Add up the numbers to arrive at a total for each section, then add the totals for each section to arrive at the grand total.

Score: If your grand total is 40 or more, your health may be adversely affected by toxicity. Consult your health practitioner to learn whether or not it is safe and appropriate for you to detoxify at this time. If so, consult an expert to determine how you can detoxify safely. Begin by choosing organic foods, drinking adequate amounts of pure water and getting enough rest.