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
___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Belching, passing gas
___ Bloated feeling
___ Heartburn
___ ***TOTAL***

EARS
___ Itchy ears
___ Earaches, ear infection
___ Drainage from ear
___ Ringing in ears
___ Hearing loss
___ ***TOTAL***

EMOTIONS
___ Mood swings
___ Anxiety, fear, nervousness
___ Anger, irritability
___ Depression
___ ***TOTAL***

ENERGY / ACTIVITY
___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness
___ ***TOTAL***

EYES
___ Watery, itchy eyes
___ Swollen, reddened, or sticky eyelids
___ Dark circles under eyes
___ Blurred/tunnel vision
___ ***TOTAL***

HEAD
___ Headaches
___ Faintness
___ Dizziness
___ Insomnia
___ ***TOTAL***

HEART
___ Skipped heartbeats
___ Rapid heartbeats
___ Chest pain
___ ***TOTAL***

JOINTS / MUSCLES
___ Pain or aches in joints
___ Arthritis
___ Stiffness, limited movement
___ Pain, aches in muscles
___ Feeling of weakness or tiredness
___ ***TOTAL***

LUNGS
___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficulty breathing
___ ***TOTAL***

MIND
___ Poor memory
___ Confusion
___ Poor concentration
___ Poor coordination
___ Difficulty making decisions
___ Stuttering, stammering
___ Slurred speech
___ Learning disabilities
___ ***TOTAL***

MOUTH / THROAT
___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarse
___ Swollen or discolored tongue, gums, lips
___ Canker sores
___ ***TOTAL***

NOSE
___ Stuffy nose
___ Sinus problem
___ Hay fever
___ Sneezing attacks
___ Excessive mucus
___ ***TOTAL***

SKIN
___ Acne
___ Hives, rashes, dry skin
___ Hair loss
___ Flushing or hot flashes
___ Excessive sweating
___ ***TOTAL***

WEIGHT
___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight
___ ***TOTAL***

OTHER
___ Frequent illness
___ Frequent or urgent need to urinate
___ Genital itch, discharge
___ ***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.