

CALCULATE YOUR TOXIC LOAD

Client Name: _____
Email address: _____

Date: _____
Phone: () _____ - _____

Rate each of the following symptoms based upon your typical health profile for the past month:

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

SYMPTOM QUESTIONNAIRE (SQ)	
HEAD <input type="checkbox"/> Headaches <input type="checkbox"/> Faintness <input type="checkbox"/> Dizziness <input type="checkbox"/> Insomnia <p style="text-align: right;">TOTAL ____</p>	G.I. TRACT <input type="checkbox"/> Nausea, vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating feeling <input type="checkbox"/> Belching, passing gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Intestinal/stomach pain <p style="text-align: right;">TOTAL ____</p>
EYES <input type="checkbox"/> Watery or itchy eyes <input type="checkbox"/> Swollen, red or sticky eyelids <input type="checkbox"/> Bags or dark circles under eyes <input type="checkbox"/> Blurred or tunnel vision <p style="text-align: right;">TOTAL ____</p>	JOINTS/ MUSCLES <input type="checkbox"/> Pain or aches in joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Stiffness or limited movement <input type="checkbox"/> Pain or aches in muscles <input type="checkbox"/> Feeling of weakness or tiredness <p style="text-align: right;">TOTAL ____</p>
EARS <input type="checkbox"/> Itchy ears <input type="checkbox"/> Earaches, ear infections <input type="checkbox"/> Drainage from ear <input type="checkbox"/> Ringing in ears, hearing loss <p style="text-align: right;">TOTAL ____</p>	WEIGHT <input type="checkbox"/> Binge eating/drinking <input type="checkbox"/> Craving certain foods <input type="checkbox"/> Excessive weight <input type="checkbox"/> Water retention <input type="checkbox"/> Underweight <input type="checkbox"/> Compulsive eating <p style="text-align: right;">TOTAL ____</p>
NOSE <input type="checkbox"/> Stuffy nose <input type="checkbox"/> Sinus problems <input type="checkbox"/> Hay fever <input type="checkbox"/> Sneezing attacks <input type="checkbox"/> Excessive mucus formation <p style="text-align: right;">TOTAL ____</p>	ENERGY/ ACTIVITY <input type="checkbox"/> Fatigue, sluggishness <input type="checkbox"/> Apathy, lethargy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Restlessness <p style="text-align: right;">TOTAL ____</p>
MOUTH/ THROAT <input type="checkbox"/> Chronic coughing <input type="checkbox"/> Gagging, frequent need to clear throat <input type="checkbox"/> Sore throat, hoarseness, loss of voice <input type="checkbox"/> Swollen or discolored tongue, gums, lips <input type="checkbox"/> Canker sores <p style="text-align: right;">TOTAL ____</p>	MIND <input type="checkbox"/> Poor memory <input type="checkbox"/> Confusion, poor comprehension <input type="checkbox"/> Difficulty in making decisions <input type="checkbox"/> Stuttering or stammering <input type="checkbox"/> Slurred speech <input type="checkbox"/> Learning disabilities <input type="checkbox"/> Poor physical coordination <input type="checkbox"/> Poor concentration <p style="text-align: right;">TOTAL ____</p>
SKIN <input type="checkbox"/> Acne <input type="checkbox"/> Hives, rashes, dry skin <input type="checkbox"/> Hair loss <input type="checkbox"/> Flushing, hot flashes <input type="checkbox"/> Excessive sweating <p style="text-align: right;">TOTAL ____</p>	EMOTIONS <input type="checkbox"/> Mood swings <input type="checkbox"/> Anxiety, fear, nervousness <input type="checkbox"/> Anger, irritability, aggressiveness <input type="checkbox"/> Depression <p style="text-align: right;">TOTAL ____</p>
HEART <input type="checkbox"/> Chest pain <input type="checkbox"/> Irregular or skipped heartbeat <input type="checkbox"/> Rapid or pounding heartbeat <p style="text-align: right;">TOTAL ____</p>	OTHER <input type="checkbox"/> Frequent illness <input type="checkbox"/> Frequent or urgent urination <input type="checkbox"/> Genital itch or discharge <p style="text-align: right;">TOTAL ____</p>
LUNGS <input type="checkbox"/> Chest congestion <input type="checkbox"/> Asthma, bronchitis <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing <p style="text-align: right;">TOTAL ____</p>	<p style="text-align: right;">GRAND TOTAL ____</p>

CHEMICAL TOLERABILITY TEST (CTT)

1. Are you currently using prescription drugs? ___ Yes (1 pt.) If yes, how many are you currently taking? ___ (1 pt. Each) ___ No (0 pt.)	6. Do you commonly experience "brain fog," fatigue, or drowsiness? ___ Yes (1 pts.) ___ No (0 pt.)
2. Are you presently taking one or more of the following over-the-counter drugs? ___ Cimetidine (Tagamet) (2 pts.) ___ Acetaminophen (Tylenol) (2 pts.) ___ Estradiol (2 pts.)	7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors? ___ Yes (1 pt.) ___ No (0 pt.) ___ Don't know (0 pt.)
3. If you have used or currently use prescription drugs, which of the following scenarios best describes your response to them: ___ Experience side effects; are efficacious at lowered doses (3 pts.) ___ Experience side effects; are efficacious at usual dose (2 pts.) ___ Experience no side effects; usually are NOT efficacious (2 pts.) ___ Experience no side effects; are usually efficacious (0 pts.)	8. Do you feel ill after you consume even a small amount of wine? ___ Yes (1 pt.) ___ No (0 pt.) ___ Don't know (0 pt.)
4. Do you currently use or within the last six months had you regularly used tobacco products? ___ Yes (2 pts.) ___ No (0 pt.)	9. Do you have a personal history of... ___ Environmental/chemical sensitivities (5 pts.) ___ Chronic fatigue syndrome (5 pts.) ___ Multiple chemical sensitivity (5 pts.) ___ Fibromyalgia (3 pts.) ___ Parkinson's type symptoms (3 pts.) ___ Alcohol or chemical dependence (2 pts.) ___ Asthma (1 pt.)
5. Do you have strong negative reactions to caffeine or caffeine containing products? ___ Yes (1 pt.) ___ No (0 pt.) ___ Don't know (0 pt.)	10. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or chemical solvents? ___ Yes (1 pt.) ___ No (0 pt.)
11. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar, and vegetables? ___ Yes (1 pt.) ___ No (0 pt.) ___ Don't know (0 pt.)	

OVERALL SCORE TABULATION

SQ SCORE	_____	(high >50; moderate 15-49; low <14)
CTT SCORE	_____	(high >10; moderate 5-9; low <4)

KEY: UNDERSTANDING YOUR SCORE

SQ score	CTT score	PLAN OF ACTION
50 or >	10 or >	if both scores are high, elevated toxic load indicated; individualized evaluation from Nutritional Concepts or your health professional highly recommended
39 or >	8 or >	if both scores are high, high-moderate elevated toxic load possible; individualized evaluation suggested or self-help: Smart Detox 3-Day, Infrared Sauna, Detox Foot Pads
15 to 38	5 to 7	if both scores are in this range, self-help suggestions: a gentle, safe elimination diet such as Smart Detox 3-Day; Infrared Sauna; Detox Foot Pads
14 or <	4 or <	minimal toxic load; keep doing what you're doing!

NOTE: clients must show high scores for both SQ and CTT to be related to toxic load. Other mechanisms should be considered by your health professional if otherwise.

NEXT STEP: INDIVIDUALIZED WRITTEN EVALUATION

Nutritional Concepts can provide the necessary tools for reducing your toxic load. By taking this questionnaire, you've done much of the work already. If your score warrants an individualized evaluation, email us at nutrocon@aol.com or go to "Private Consultations" at www.nutritionalconcepts.com. Under Bonnie's Scheduling Menu, go to *Toxic Load Written Evaluation*. Once we receive all completed forms with \$50.00 payment, we will analyze your results and, in writing, provide an individualized plan of action.

TOXIC LOAD WRITTEN EVALUATION REQUIREMENTS

Please mail, fax, or email the following completed materials with a check payable to Nutritional Concepts or VISA/MC/DISC (you may phone in your credit card with expiration date or write it below) for \$50.00.

Upon receiving your materials, it will take approximately 7 business days to submit our findings to you.

Please indicate below how you would like us to remit your evaluation results.

CHECKLIST (please check off all)

- Calculate Your Toxic Load Worksheet (should already have been completed)
- Client Information (below)
- Toxic Load Addendum (below)
- \$50.00 check or VISA/MC _____ exp _____
- I would like my evaluation results sent by (check one): ___ Email ___ Fax ___ Postal Mail

CLIENT INFORMATION

Client Name: _____ Primary Email: _____ Secondary Email: _____ Home Street: _____ Home City: _____ Occupation: _____ List all current medications (including aspirin): _____ _____	Date: _____ Phone: (____) ____ - ____ Cell: (____) ____ - ____ Apt #: _____ Zip Code: _____ - ____ State: _____ Birthday: ____ / ____ / ____ Fax: (____) ____ - ____ Referred: _____ Doctor: _____
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TOXIC LOAD ADDENDUM

1. Do you have a household mold problem? ___ Yes ___ No	6. Do you feel your workplace is toxic? ___ Yes ___ No If yes, please explain: _____ _____ _____
2. Do you microwave with plastic containers? ___ Yes ___ No	7. Have you ever been tested for toxicity? ___ Yes ___ No If yes, please list test(s): _____ _____ _____
3. Do you have silver dental amalgams in your mouth? ___ Yes ___ No	8. Do you currently use any detoxification modalities, products, or protocols? ___ Yes ___ No If yes, please list: _____ _____ _____
4. How would you describe your cell phone use? ___ 2 or more hours daily ___ 1-2 hours daily ___ Less than one hour daily	5. Do you live within 100 ft of high voltage electrical wires? ___ Yes ___ NO ___ I'm not sure

I use or consume...	Frequently		Sometimes		Never
Conventional Deodorant/Antiperspirant					
Perfume					
Hair Dye					
Conventional Sunscreen					
Conventional Air Fresheners					
Conventional Cosmetics					
Conventional Bath & Body Products					
Conventional Household Cleaning Products					
Conventional Dish & Laundry Products					
Conventional Lawn Care Chemicals					
Conventional Dry Cleaning					
Conventional Paints, Varnishes, & Building Materials					
Insecticides/Animal Poisons					
Reuse plastic containers					
Saran Wrap					
Tap Water					
Conventional Produce					
Grilled or Charred Foods					
Foods with Additives & Preservatives					
Foods Containing Artificial Color					
Artificial Sweeteners					
Conventional Meat & Poultry					
Conventional Milk & Dairy					
More than 2 cups coffee daily					
Decaffeinated coffee					
Fried foods					
Non-Organic Soy Products					

THE END

We appreciate you taking the time to fill out the required forms. Please send with payment to:

nutrocon@aol.com Email

(847) 509-9069 Fax

**Nutritional Concepts
1535 Lake Cook Rd.
Suite 204
Northbrook, IL 60062**

PLEASE MAKE ANY NOTES OR COMMENTS THAT MAY BE HELPFUL TO YOUR EVALUATION:

