

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)

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

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.