
Toxicity QUESTIONNAIRE

INTEGRATIVE WELLNESS ADVISORS

The Toxicity Questionnaire is a short self-assessment that will help you determine how toxic your body is now, based on the symptoms or conditions you're experiencing. This is your toxicity score "base case."

You may find it helpful to take this questionnaire again every 1-3 months to determine what (if anything) has changed. This comparison will give you valuable information about how your body is reacting to changes in your diet and lifestyle over time.

Respond "yes" or "no" to each question (keep in mind: "maybe" counts as "yes") based on your experience for the past 60 days.

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|--------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <input type="checkbox"/> Sugar cravings? | <input type="checkbox"/> Chest congestion? |
| <input type="checkbox"/> Hunger that's difficult to satisfy? | <input type="checkbox"/> Asthma or wheezing? |
| <input type="checkbox"/> Low or inconsistent energy? | <input type="checkbox"/> Migraines or headaches? |
| <input type="checkbox"/> Fatigue, especially after exercise? | <input type="checkbox"/> Ringing in ears? |
| <input type="checkbox"/> Constipation? | <input type="checkbox"/> Depression? |
| <input type="checkbox"/> Difficulty sleeping restoratively? | <input type="checkbox"/> Anxiety? |
| <input type="checkbox"/> Caffeine addiction? | <input type="checkbox"/> Mood swings? |
| <input type="checkbox"/> Bloating or gas? | <input type="checkbox"/> Irritation? |
| <input type="checkbox"/> Reflux or heartburn? | <input type="checkbox"/> Brain fog or difficulty with concentration? |
| <input type="checkbox"/> Irritable bowel? | <input type="checkbox"/> Distractibility? |
| <input type="checkbox"/> Difficulty losing weight? | <input type="checkbox"/> Skin problems, such as acne, rosacea, eczema, or rashes? |
| <input type="checkbox"/> Binge eating or drinking? | <input type="checkbox"/> Joint problems or pain? |
| <input type="checkbox"/> Fluid retention? | <input type="checkbox"/> Muscle aches? |
| <input type="checkbox"/> Stuffy or runny nose, itchy nose or eyes? | |

Total score _____

Today's date _____