Toxicity Test

Patient Name: _____ **Date:** _____

Rate each of the following symptoms based on your typical health profile for the last 30 days.

Point Scale: **0 -** Never or almost never. **1-** Occasionally. Effect is not severe **2 -** Occasionally. Effect is severe
3 - Frequently. Effect is not severe **4 -** Frequently. Effect is severe

Symptoms Questionnaire

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
TOTAL_____

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
TOTAL_____

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
TOTAL_____

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
TOTAL_____

MOUTH/ THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
TOTAL_____

HEART
_____ Chest Pain
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
TOTAL_____

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
TOTAL_____

DIGESTIVE TRACT
_____ Nausea, Vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
TOTAL_____

JOINTS/ MUSCLES
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Feeling of weakness or tiredness
_____ Pain or aches in muscles
TOTAL_____

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Water retention
_____ Underweight
_____ Compulsive eating
TOTAL_____

ENERGY/ ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
TOTAL_____

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ Poor concentration
_____ Poor Physical coordination
TOTAL_____

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
TOTAL_____

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
TOTAL_____
GRAND TOTAL _____

1. Are you presently using prescription drugs?
☐ Yes (1pt.)
If yes, how many are you currently taking?_____(1pt. each)
☐ No (0pt.)

2. Are you presently taking one or more of the following over-the-counter drugs?
☐ Cimetidine (2pts.)
☐ Acetaminophen (2pts.)
☐ Estradiol (2pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
☐ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3pts.)
☐ Experience side effects, drug(s) is (are) efficacious at usual dose(s) dose(s) (2pts.)
☐ Experience no side effects, drug(s) is (are) usually not efficacious (2pts.)
☐ Experience no side effects, drug(s) is (are) usually efficacious (0pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?
☐ Yes (2pts.) ☐ No (0pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?
☐ Yes (1pts.) ☐ No (0pt.)

6. Do you commonly experience "brain fog", fatigue, or drowsiness?
☐ Yes (1pt.) ☐ No (0pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
☐ Yes (1pt.) ☐ No (0pt.) ☐ Don't know (0pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
☐ Yes (1pt.) ☐ No (0pt.) ☐ Don't know (0pt.)

9. Do you have a personal history of
☐ Environmental and/or chemical sensitivities (5pts.)
☐ Chronic fatigue syndrome (5pts.)
☐ Multiple chemical sensitivity (5pts.)
☐ Fibromyalgia (3pts.)
☐ Parkinson's type symptoms (3pts.)
☐ Alcohol or chemical dependence (2pts.)
☐ Asthma (1pt.)

10. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
☐ Yes (1pt.) ☐ No (0pt.)

11. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?
☐ Yes (1pt.) ☐ No (0pt.) ☐ Don't know (0pt.)

GRAND TOTAL _____

FOR PRACTITIONER USE ONLY.

Patients with chronic constipation should take Frontier Cleanse (4 capsules) one hour after meals up to three times per day

OVERALL SCORE TABULATION

Before Cleanse:	**After Cleanse:**	**% Difference**
SQ Score _____ (High >50; moderate 15-49; low <14)	**SQ Score** _____ (High >50; moderate 15-49; low <14)	_____
TT Score _____ (High >10; moderate 5-9; low <4)	**TT Score** _____ (High >10; moderate 5-9; low <4)	_____

SQ Score	TT Score	Description	Functional Medicine Protocol		
			Meal Replacement Powder (MRP)	Diet	Additional Nutrition Support
50 or >	10 or >	High level or general symptoms and indicated symptoms of elevated toxic load	Power Cleanse or Super Shake / Best Whey	**30 Day Cleanse** 1 Shake per day 3 Meals	LivClear II Liver/Gallbladder Tincture Ener DMG Pro Colors
15-49	5-9	Moderate level of general symptoms with moderate symptoms of toxic load	Power Cleanse or Super Shake / Best Whey	**15 Day Cleanse** 2 Shake per day 2 Meals	LivClear II Liver/Gallbladder Tincture Ener DMG Pro Colors
14 or <	4 or <	Low level of general symptoms and minimal indicators of toxic load	Power Cleanse or Super Shake / Best Whey	**10 Day Cleanse** 3 Shake per day 1 Meals	**Maintenance:** LivClear II Pro Colors

Symptom-Specific Support	
Water Retention and/or frequent or urgent urination	K&B Tincture
Heartburn and/or intestinal/stomach pain	ProbZyme
Diarrhea, constipation, and/or intestinal/stomach pain	Frontier Biotics