

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

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

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) (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)	Additional Nutrition Support
50 or >	10 or >	High level or general symptoms and indicated symptoms of elevated toxic load	Power Cleanse or Pro Lean Greens	LivComplete Liver/Gallbladder Tincture
15-49	5-9	Moderate level of general symptoms with moderate symptoms of toxic load	Pro Lean Greens or Super Shake / Best Whey	LivComplete Liver/Gallbladder Tincture
14 or <	4 or <	Low level of general symptoms and minimal indicators of toxic load	Pro Lean Greens or Super Shake / Best Whey	Maintenance: LivComplete
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	