CENTER FOR ALTERNATIVE MEDICINE

PATIENT QUESTIONNAIRE

Biotoxicity Symptom Questionnaire

Name _____ Date _____

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

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 10 or more, or the grand total is **50** or more, you may benefit from a detoxification program.

POINT SCALE

- **0** Never or almost never have the symptoms
- **1** Occasionally has it, effect is not severe
- **2** Occasionally has it, effect is severe
- **3** Frequently has it, effect is not severe
- **4** Frequently has it, effect is severe

_____ RATE EACH SYMPTOM 0–4

DIGESTIVE

_____ Nausea or vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ TOTAL

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervous
_____ Anger, irritability
_____ Depression
_____ TOTAL

EYES

_____ Watery, itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Dark circles under eyes
_____ Blurred/tunnel vision
_____ TOTAL

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
_____ TOTAL

EARS

_____ Itchy ears
_____ Earaches, ear infection
_____ Drainage from ear
_____ Ringing in ears, hearing loss
_____ TOTAL

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, sluggishness
_____ Hyperactivity
_____ Restlessness
_____ TOTAL

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
_____ TOTAL

MIND

_____ Poor memory
_____ Confusion
_____ Poor concentration
_____ Poor coordination
_____ Difficulty making decisions
_____ Stuttering, stammering
_____ Slurred speech
_____ Learning disabilities
_____ TOTAL

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, need to clear throat
_____ Sore throat, hoarse
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores
_____ TOTAL

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing or hot flashes
_____ Excessive sweating
_____ TOTAL

JOINT/MUSCLES

_____ Pain or aches in joints
_____ Arthritis
_____ Stiff, limited movement
_____ Pain, aches in muscles
_____ Weakness or tiredness
_____ TOTAL

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus
_____ TOTAL

HEART

_____ Skipped heartbeats
_____ Rapid heartbeats
_____ Chest pain
_____ TOTAL

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight gain
_____ Compulsive eating
_____ Water retention
_____ Underweight
_____ TOTAL

OTHER

_____ Frequent illness
_____ Frequent/urgent urination
_____ Genital itch, discharge
_____ TOTAL

Grand Total _____