Symptom & Toxicity Checklist

The Toxicity and Symptom Screening Questionnaire assesses symptoms that help to identify the underlying causes of illness, and helps you track your progress over time.

Rate each of the following symptoms based upon your health profile for the **past 7-14 days.**

Name:_____

Date:_____

Instructions:

Please review each health score area that corresponds with a health/body area. Write down the corresponding amount of points per item in that area. Once you complete filling out that area, total your point and record it in the TOTAL field. When you come to the end of the survey add up all the totals from each area together to arrive at your GRAND TOTAL. Please record that GRAND TOTAL and share the results with me.

0	1	2	3	4
Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe

Symptom & Toxicity Checklist

Ears

Itchy Ears Earaches	_____
Ear Infections	_____
Drainage from Ear	_____
Ringing in Ears	_____
Hearing Loss Red	_____
Burning Ears	_____
Total:	_____

Mouth/Throat

Chronic Coughing Gagging	_____
Frequent Need to Clear throat	_____
Sore Throat, Hoarseness	_____
Swollen/Discolored Tongue/Gums	_____
Canker Sores	_____
Cracking at Corner of Lips	_____
Total:	_____

Head

Headaches	_____
Faintness	_____
Dizziness	_____
Insomnia	_____
Total:	_____

Revival
NUTRITION AND HEALTH

Symptom & Toxicity Checklist

Nose

Stuffy Nose	_____
Sinus Problem	_____
Hay Fever/Seasonal Allergies	_____
Sneezing Attacks	_____
Excessive Mucus Formation	_____
Total:	_____

Eyes

Watery or Itchy Eyes	_____
Swollen, Reddened or Sticky Eyelids	_____
Bags or Dark Circles Under Eyes	_____
Swollen/Discolored Tongue/Gums	_____
Blurred or Tunnel Vision	_____
Floaters	_____
Total:	_____

Skin

Acne	_____
Hives, Rash	_____
Dry Skin	_____
Hair Loss	_____
Flushing	_____
Hot Flashes/Excessive Sweating	_____
Total:	_____

Joints/Muscles

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Pain or Aches in Joints	_____
Stiffness or Limitation of Movement	_____
Pain or Aches in Muscles	_____
Feeling of Weakness or Tiredness	_____
Pain that Moves from Joint to Joint	_____
Total:	_____

Digestive Tract

Nausea or Vomiting	_____
Diarrhea	_____
Constipation	_____
Bloated	_____
Belching or Passing Gas	_____
Heartburn	_____
Blood in Stool	_____
Mucous in Stool	_____
Heartburn or Indigestion	_____
Intestinal or Stomach Pain	_____
Total:	_____

Heart

Chest Pain	_____
Irregular or Skipped Heartbeat	_____
Rapid or Pounding Heartbeat	_____
Chest Pain	_____
Total:	_____

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Lungs

Chest Congestion	_____
Asthma	_____
Bronchitis	_____
Difficulty Breathing	_____
Total:	_____

Weight

Binge Eating/Drinking	_____
Craving Certain Foods	_____
Excessive Weight	_____
Compulsive Eating	_____
Water Retention	_____
Underweight	_____
Total:	_____

Energy/Activity

Hyperactivity Worst with Exercise Better with Naps Lethargy	_____
Fatigue	_____
Hyperactivity that is worse with exercise and better with naps	_____
Total:	_____

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Mind

Poor Memory Confusion	_____
Poor Comprehension	_____
Poor Physical Coordination	_____
Difficulty in Making Decisions	_____
Stuttering or Slurred Speech	_____
Learning Disabilities	_____
Total:	_____

Emotions

Mood Swings	_____
Anxiety	_____
Fear	_____
Depression	_____
Overwhelm	_____
Anger	_____
Total:	_____

Add together the total from each health/body related area and put the number below in the GRAND TOTAL field.

Grand Total: _____

<10	10-50	50-100	100>
Optimal	Mild Toxicity	Moderate Toxicity	Severe Toxicity