Toxicity Quiz

How toxic are you? Find out NOW!

This quiz is designed to look at your health and lifestyle to determine if you are experiencing toxicity symptoms and if you are at a high risk for toxin exposure. This is a good gauge to determine if a detox program would be a good fit for you!

SECTION 1: SYMPTOMS

INSTRUCTIONS:
Circle the corresponding number to describe the frequency and severity of the symptom. Rate each of the following based upon your health for the past 30 days.

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

Digestion					
Nausea or vomiting	0	1	2	3	4
Diarrhea	0	1	2	3	4
Constipation	0	1	2	3	4
Bloated Feeling	0	1	2	3	4
Belching and/or Passing Gas	0	1	2	3	4
Heartburn	0	1	2	3	4
Intestinal or Stomach Pain	0	1	2	3	4
Digestion Subtotal					

Emotions					
Mood Swings	0	1	2	3	4
Anxiety, Fear, or Nervousness	0	1	2	3	4
Anger, Irritability	0	1	2	3	4
Depression	0	1	2	3	4
Sense of Despair	0	1	2	3	4
Uncaring or Unmotivated in Life	0	1	2	3	4
Emotions Subtotal					

Ears	
Itchy Ears	0 1 2 3 4
Earaches or Ear Infections	0 1 2 3 4
Drainage from ears	0 1 2 3 4
Ringing in Ears	0 1 2 3 4
Hearing Loss	0 1 2 3 4
Ears Subtotal	

Energy/Activity	
Fatigue or Sluggishness	0 1 2 3 4
Hyperactivity	0 1 2 3 4
Restlessness	0 1 2 3 4
Insomnia	0 1 2 3 4
Startled Awake at Night	0 1 2 3 4
Energy Subtotal	

Eyes	
Watery or Itchy Eyes	0 1 2 3 4
Swollen, Reddened or Sticky Eyelids	0 1 2 3 4
Dark Circles Under Eyes	0 1 2 3 4
Blurred or Tunnel Vision	0 1 2 3 4
Eyes Subtotal	

Head	
Headaches	0 1 2 3 4
Faintness	0 1 2 3 4
Dizziness	0 1 2 3 4
Pressure in Head	0 1 2 3 4
Head Subtotal	

Heart	
Skipped Heartbeats	0 1 2 3 4
Rapid Heartbeats	0 1 2 3 4
Chest Pain	0 1 2 3 4
Heart Subtotal	

Joints/Muscles	
Pain or Aches in Joints	0 1 2 3 4
Arthritis	0 1 2 3 4
Stiffness or Limited Movement	0 1 2 3 4
Pain or Aches in Muscles	0 1 2 3 4
Recurrent Back Aches	0 1 2 3 4
Feeling of Weakness or Tiredness	0 1 2 3 4
Joints/Muscles Subtotal	

Mind	
Poor Memory	0 1 2 3 4
Confusion	0 1 2 3 4
Poor Concentration	0 1 2 3 4
Poor Coordination	0 1 2 3 4
Difficulty Making Decisions	0 1 2 3 4
Stuttering, Stammering	0 1 2 3 4
Slurred Speech	0 1 2 3 4
Learning Disabilities	0 1 2 3 4
Mind Subtotal	

Nose	
Stuffy Nose	0 1 2 3 4
Sinus Problems	0 1 2 3 4
Hay Fever	0 1 2 3 4
Sneezing Attacks	0 1 2 3 4
Excessive Mucous	0 1 2 3 4
Allergies	0 1 2 3 4
Nose Subtotal	

Mouth/Throat	
Chronic Coughing	0 1 2 3 4
Gagging or Frequent Need to Clear Throat	0 1 2 3 4
Swollen or Discolored Tongue, Gums, Lips	0 1 2 3 4
Canker Sores	0 1 2 3 4
Mouth/Throat Subtotal	

Lungs	
Chest Congestion	0 1 2 3 4
Asthma or Bronchitis	0 1 2 3 4
Shortness of Breath	0 1 2 3 4
Difficulty Breathing	0 1 2 3 4
Lungs Subtotal	0 1 2 3 4

Skin	
Acne	0 1 2 3 4
Hives, Rashes, or Dry Skin	0 1 2 3 4
Hair Loss	0 1 2 3 4
Flushing	0 1 2 3 4
Excessive Sweating	0 1 2 3 4
Skin Subtotal	

Weight	
Binge Eating or Drinking	0 1 2 3 4
Craving Certain Foods	0 1 2 3 4
Excessive Weight	0 1 2 3 4
Compulsive Eating	0 1 2 3 4
Water Retention	0 1 2 3 4
Underweight	0 1 2 3 4
Weight Subtotal	

Other	
Frequent Illness	0 1 2 3 4
Frequent or Urgent Urination	0 1 2 3 4
Leaky Bladder	0 1 2 3 4
Genital Itch, Discharge	0 1 2 3 4
Other Subtotal	

Total for Section 1: _____

SECTION 2: RISK OF EXPOSURE

Circle the corresponding number to describe your frequency of exposure.

	Never	Rarely	Monthly	Weekly	Daily
How often are strong chemicals used in your home? (bleach, window cleaners, disinfectants)	0	1	2	3	4
How often are pesticides used in your home?	0	1	2	3	4
How often do you have your home treated for insects?	0	1	2	3	4
How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, or incense in your home or office?	0	1	2	3	4
How often are you exposed to nail polish, perfume, hairspray or other cosmetics?	0	1	2	3	4
How often are you exposed to diesel exhaust or gas fumes?	0	1	2	3	4
How often do you consume non-organic food?	0	1	2	3	4
Total					

Circle the corresponding number to describe your level of change.

	None	Mild	Moderate	Drastic
Have you noticed any negative change in your health since you moved into your current living space?	0	1	2	3
Have you noticed any change in your health since you started a new job?	0	1	2	3
Total				

Answer yes or no to the following questions

	NO	YES
Do you have a water purification system in your home?	2	0
Do you have an air purification system in your home?	2	0
Do you have any indoor pets?	0	2
Are you a dentist, painter, farmer or construction worker?	0	2
Total		

Total for Section 2: _____

RESULTS

To calculate your grand total, combine your total scores from section 1 and section 2. If any individual section equals a six or more, OR if your grand total is 40 or greater, you may benefit from a detoxification program.

Section 1 + Section 2 = My Grand Total = _____

Dr Stephanie Zgraggen