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 (SQ)

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

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 ___

HEAD
___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

TOTAL ___

FACE
___ 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 or 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 ___

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

TOTAL ___

ENERGY/ACTIVITY
___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

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

_____

Tolerability Test (TT)

Are you presently using prescription drugs?

☐ Yes (1 pt.)

If yes, how many are you currently taking?

☐ ___ (1 pt. each) ☐ No (0 pts.)

Are you presently taking one or more of the following over-the-counter drugs?

☐ Cimetidine (2 pts.)
☐ Acetaminophen (2 pts.)
☐ Estradiol (2 pts.)

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) (3 pts.)
☐ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)
☐ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)
☐ Experience no side effects, drug(s) is (are) usually efficious (0 pts.)

Do you currently use or within the last 6 months have you regularly used tobacco/vape products?

☐ Yes (2 pts.) ☐ No (0 pts.)

Do you have strong negative reaactions to caffeine or caffeine containing products?

☐ Yes (2 pts.) ☐ No (0 pts.) ☐ I don't know (0 pts.)

Do you commonly experience "brain fog", fatigue, or drowsiness?

☐ Yes (1 pt.) ☐ No (0 pts.)

Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?

☐ Yes (1 pt.) ☐ No (0 pts.) ☐ I don't know (0 pts.)

Do you feel ill after you consume even small amounts of alcohol?

☐ Yes (1 pt.) ☐ No (0 pts.) ☐ I don't know (0 pts.)

Do you have a personal history of

☐ Environmental and/or chemical sensitivites (5 pts.)
☐ Chronic fatigue syndrome (5 pts.)
☐ Multiple chemical sensitivity (5 pts.)
☐ Fibromyalgia (3 pts.)
☐ Parkinson's type symptoms (3 pts.)
☐ Alcohol or chemical dependence (2 pts.)
☐ Asthma (1 pt.)

Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?

☐ Yes (1 pt.) ☐ No (0 pts.)

Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?

☐ Yes (1 pt.) ☐ No (0 pts.) ☐ I don't know (0 pts.)

GRAND TOTAL _____

FOR PRACTITIONER USE ONLY: Patients with chronic constipation should take MaxLax (1 capsule) 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	Diet	Additional Nutrition Support
50 or >	10 or >	High level or general symptoms and indicated symptoms of elevated toxic load	Ultimate Shake Pro Lean Greens GI Complete	30 day cleanse 1 shake per day 3 meals	LivComplete Liver/Gallbladder Tincture Remove Complete
15-49	5-9	Moderate level of general symptoms with moderate symptoms of toxic load	Pro Lean Greens Super Shake / Best Whey UT Cleanse	15 day cleanse 2 shakes per day 2 meals	LivComplete Liver/Gallbladder Tincture
14 or <	4 or <	Low level of general symptoms and minimal indicators of toxic load	Ultimate Shake Pro Lean Greens	10 day cleanse 3 shakes per day 1 meal	LivComplete

Symptom-Specific Support	
Water retention and/or frequent or urgent urination	UT Cleanse
Heartburn and/or intestinal/stomach pain	ProbZyme
Constipation and/or heavy metals	MaxLax/Remove Complete