

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	3 - Frequently, effect is not severe
1 - Occasionally, effect is not severe	4 - Frequently, effect is severe
2 - Occasionally, effect is severe	

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

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 efficacious (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 reactions 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 sensitivities (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