Toxic Burden Questionnaire

Section 1: Symptoms

Name _____ Date _____

RATING SCALE:

0 = Never **1 = Occasionally** **2 = Frequently**

Rate each of the following based on your health over the past 90 days. Circle the corresponding number.

Digestive

Bowel movements less than once per day	0 1 2
Bloated feeling	0 1 2
Belching or gas	0 1 2
Heartburn	0 1 2

Total _____

Ears

Itchy ears	0 1 2
Earaches	0 1 2
Drainage from ear	0 1 2
Ringing in ears or hearing loss	0 1 2

Total _____

Hair, Skin & Nails

Acne	0 1 2
Hair loss or thinning	0 1 2
Body odor	0 1 2
Discoloration or bands in fingernails	0 1 2

Total _____

Head

Headaches	0 1 2
Pressure	0 1 2
Dizziness	0 1 2
Faintness	0 1 2

Total _____

Eyes

Watery or itchy eyes	0 1 2
Swollen or reddened eyelids	0 1 2
Dark circles under the eyes	0 1 2
Blurred vision (excluding near- or far-sightedness)	0 1 2

Total _____

Joints & Muscles

Pain or aches in joints or lower back	0 1 2
Stiffness or limitation in movement	0 1 2
Pain or aches in muscles	0 1 2
Feelings of weakness or tiredness	0 1 2

Total _____

Emotions

Mood swings	0 1 2
Feelings of fear or nervousness	0 1 2
Anger or irritability	0 1 2
Feelings of sadness	0 1 2

Total _____

Nose

Stuffy nose	0 1 2
Sinus congestion	0 1 2
Sneezing	0 1 2
Mucus	0 1 2

Total _____

Heart & Circulation

Skipped heartbeats	0 1 2
Rapid heartbeats	0 1 2
Chest discomfort	0 1 2
Leg cramps with activity	0 1 2

Total _____

Mind

Poor memory or confusion	0 1 2
Difficulty concentrating	0 1 2
Poor coordination	0 1 2
Difficulty making decisions	0 1 2

Total _____

Lungs

Shortness of breath	0 1 2
Difficulty breathing	0 1 2
Chest congestion	0 1 2
Coughing	0 1 2

Total _____

Weight

Overweight	0 1 2
Difficulty losing weight	0 1 2
Crave certain foods	0 1 2
Excessive sweating	0 1 2

Total _____

Energy & Activity

Fatigue or sluggishness	0 1 2
Hyperactivity	0 1 2
Restlessness	0 1 2
Difficulty falling or staying asleep	0 1 2

Total _____

Mouth & Throat

Gagging or frequent need to clear throat	0 1 2
Hoarseness or loss of voice	0 1 2
Dental problems	0 1 2
Metallic taste in mouth	0 1 2

Total _____

Other

Food sensitivities	0 1 2
Chemical or environmental sensitivities	0 1 2
Frequent or urgent urination	0 1 2
Bloating or mood swings before menstruation	0 1 2

Total _____

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Interpreting Your Score:

If the Section 1 total is more than 30 **and** at least four categories have a score of 5 or more, then your responses suggest potential toxic burden. Please talk with your health care provider about how Core Restore® can help.

This is a screening tool, and not a diagnostic tool. The purpose of this questionnaire is to help determine an association between symptoms and potential toxic burden.

SECTION 1 TOTAL _____

Toxic Burden Questionnaire

Section 2: Risk of Exposure

Name _____ Date _____

RATING SCALE:

0 = No, never **1 = Yes, but not in the past year** **2 = Yes, intermittent in the last year** **3 = Yes, currently or ongoing**

Rate each of the following based on your environmental exposure. Circle the corresponding number.

Heavy Metal Exposures:

Do you live in a home that has plumbing pipes or fixtures installed before 1986?	0 1 2 3
Do you use unfiltered water for drinking and cooking?	0 1 2 3
Do you have root canals, extracted teeth, dental implants, "silver" fillings, crowns, dental sealants, dentures or braces?	0 1 2 3
Do you eat seafood (including farmed seafood)?	0 1 2 3
Do you consume canned foods?	0 1 2 3
Do you live or work around exhaust fumes, tobacco smoke, cleaning chemicals, paint or other volatile fumes?	0 1 2 3

Mycotoxin Exposures:

Do you live or work in an area with signs of mold or water damage (e.g., cracking paint, ceiling leaks, decaying insulation or foam, visible mold, or damp areas in windows, crawlspaces, or basements)?	0 1 2 3
Do you drink water from a well or cistern?	0 1 2 3
Do you consume nuts, grains, beans, seeds, coffee, sugar, dried fruit or hard cheeses that have been stored for a prolonged period or in warm or humid conditions?	0 1 2 3

Common Food Exposures:

Do you eat conventionally farmed (non-organic) or genetically modified fruits and vegetables?	0 1 2 3
Do you eat conventionally raised (non-organic) animal products (e.g., meat, poultry, dairy or eggs)?	0 1 2 3
Do you eat processed foods (e.g., foods with added artificial colors, flavors or preservatives)?	0 1 2 3
Do you live or work in an agricultural or other area where you are exposed to pesticides, herbicides or fungicides?	0 1 2 3
Do you consume tofu?	0 1 2 3

Hormone-Altering Exposures:

Do you use the microwave to prepare prepackaged meals or reheat food in Styrofoam or other non-ceramic or non-glass containers?	0 1 2 3
Do you drink beverages from plastic bottles?	0 1 2 3
Do you use nonstick Teflon pans for cooking in your home?	0 1 2 3
Are you taking hormone replacement therapy (including bioidentical hormone therapy)?	0 1 2 3

Other:

Do you have food reactions, sensitivities or intolerances?	0 1 2 3
Do you drink sodas, juices or other beverages with refined or artificial sweeteners?	0 1 2 3
Do you eat deep-fried or fast foods?	0 1 2 3
Do you take any over-the-counter (acetaminophen, ibuprofen, naproxen, etc.) or prescriptive medications (antibiotics, opioids, etc.)?	0 1 2 3
Do you lead a high-stress lifestyle or have prolonged exposure to mental or emotional stress?	0 1 2 3

Please share your risk of exposure ratings with your provider.