

## Toxicity Quiz: Are You Sick?

For the “before” part of the questionnaire, rate each of the following symptoms based upon your health during the last 30 days. Then, take this quiz again after *The 10-Day Detox Diet* and note how you feel right after the Detox. It’s especially important that you take the time to complete and score it now, before you embark on the program. Without that baseline score, several days from now, you may have a hard time believing just how much better your “after” results really are!

### POINT SCALE

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

DIGESTIVE TRACT	RATING BEFORE	RATING AFTER	DIFFERENCE
Nausea or vomiting	0 1 2 3 4	0 1 2 3 4	
Diarrhea	0 1 2 3 4	0 1 2 3 4	
Constipation	0 1 2 3 4	0 1 2 3 4	
Bloated feeling	0 1 2 3 4	0 1 2 3 4	
Belching, or passing gas	0 1 2 3 4	0 1 2 3 4	
Heartburn	0 1 2 3 4	0 1 2 3 4	
Intestinal or stomach pain	0 1 2 3 4	0 1 2 3 4	

### DIGESTIVE TRACT Subtotal

\_\_\_\_\_

\_\_\_\_\_

EARS	RATING BEFORE	RATING AFTER	DIFFERENCE
Itchy ears	0 1 2 3 4	0 1 2 3 4	
Earaches, ear infections	0 1 2 3 4	0 1 2 3 4	
Drainage from ear	0 1 2 3 4	0 1 2 3 4	

Ringing in ears, hearing loss	0 1 2 3 4	0 1 2 3 4
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**EARS Subtotal**      \_\_\_\_\_      \_\_\_\_\_

**EMOTIONS**

Mood swings	0 1 2 3 4	0 1 2 3 4
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Anxiety, fear, or nervousness	0 1 2 3 4	0 1 2 3 4
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Anger, irritability, or aggressiveness	0 1 2 3 4	0 1 2 3 4
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Depression	0 1 2 3 4	0 1 2 3 4
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**EMOTIONS Subtotal**      \_\_\_\_\_      \_\_\_\_\_

**ENERGY/ACTIVITY**

Fatigue, sluggishness	0 1 2 3 4	0 1 2 3 4
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Apathy, lethargy	0 1 2 3 4	0 1 2 3 4
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Hyperactivity	0 1 2 3 4	0 1 2 3 4
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Restlessness	0 1 2 3 4	0 1 2 3 4
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**ENERGY/ACTIVITY Subtotal**      \_\_\_\_\_      \_\_\_\_\_

**EYES**

Watery or itchy eyes	0 1 2 3 4	0 1 2 3 4
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Swollen, reddened, or sticky eyelids	0 1 2 3 4	0 1 2 3 4
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Bags or dark circles under eyes	0 1 2 3 4	0 1 2 3 4
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Blurred or tunnel vision (does not include near- or far-sightedness)	0 1 2 3 4	0 1 2 3 4
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**EYES Subtotal**      \_\_\_\_\_      \_\_\_\_\_

**HEAD**

Headaches	0 1 2 3 4	0 1 2 3 4
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Faintness	0 1 2 3 4	0 1 2 3 4
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Dizziness	0 1 2 3 4	0 1 2 3 4
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Insomnia	0 1 2 3 4	0 1 2 3 4
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<b>HEAD Subtotal</b>	_____	_____
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### HEART

Irregular or skipped heartbeat	0 1 2 3 4	0 1 2 3 4
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Rapid or pounding heartbeat	0 1 2 3 4	0 1 2 3 4
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Chest pain	0 1 2 3 4	0 1 2 3 4
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<b>HEART Subtotal</b>	_____	_____
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### JOINTS/MUSCLES

Pain or aches in joints	0 1 2 3 4	0 1 2 3 4
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Arthritis	0 1 2 3 4	0 1 2 3 4
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Stiffness or limitation of movement	0 1 2 3 4	0 1 2 3 4
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Pain or aches in muscles	0 1 2 3 4	0 1 2 3 4
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Feeling of weakness or tiredness	0 1 2 3 4	0 1 2 3 4
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<b>JOINTS/MUSCLES Subtotal</b>	_____	_____
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### LUNGS

Chest congestion	0 1 2 3 4	0 1 2 3 4
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Asthma or bronchitis	0 1 2 3 4	0 1 2 3 4
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Shortness of breath	0 1 2 3 4	0 1 2 3 4
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Difficulty breathing	0 1 2 3 4	0 1 2 3 4
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<b>LUNGS Subtotal</b>	_____	_____
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### MIND

Poor memory	0 1 2 3 4	0 1 2 3 4
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Confusion or poor comprehension	0 1 2 3 4	0 1 2 3 4
Poor concentration	0 1 2 3 4	0 1 2 3 4
Poor physical coordination	0 1 2 3 4	0 1 2 3 4
Difficulty in making decisions	0 1 2 3 4	0 1 2 3 4
Stuttering or stammering	0 1 2 3 4	0 1 2 3 4
Slurred speech	0 1 2 3 4	0 1 2 3 4
Learning disabilities	0 1 2 3 4	0 1 2 3 4

**MIND Subtotal**      \_\_\_\_\_      \_\_\_\_\_

**MOUTH/THROAT**

Chronic coughing	0 1 2 3 4	0 1 2 3 4
Gagging, frequent need to clear throat	0 1 2 3 4	0 1 2 3 4
Sore throat, hoarseness, or loss of voice	0 1 2 3 4	0 1 2 3 4
Swollen or discolored tongue, gums, or lips	0 1 2 3 4	0 1 2 3 4
Canker sores	0 1 2 3 4	0 1 2 3 4

**MOUTH/THROAT Subtotal**      \_\_\_\_\_      \_\_\_\_\_

**NOSE**

Stuffy nose	0 1 2 3 4	0 1 2 3 4
Sinus problems	0 1 2 3 4	0 1 2 3 4
Hay fever	0 1 2 3 4	0 1 2 3 4
Excessive mucus formation	0 1 2 3 4	0 1 2 3 4
Sneezing attacks	0 1 2 3 4	0 1 2 3 4

**NOSE Subtotal**      \_\_\_\_\_      \_\_\_\_\_

**SKIN**

Acne	0 1 2 3 4	0 1 2 3 4
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Hives, rashes, or dry skin	0 1 2 3 4	0 1 2 3 4
Hair loss	0 1 2 3 4	0 1 2 3 4
Flushing or hot flushes	0 1 2 3 4	0 1 2 3 4
Excessive sweating	0 1 2 3 4	0 1 2 3 4
<b>SKIN Subtotal</b>	_____	_____
<b>WEIGHT</b>		
Binge eating/drinking	0 1 2 3 4	0 1 2 3 4
Craving certain foods	0 1 2 3 4	0 1 2 3 4
Excessive weight	0 1 2 3 4	0 1 2 3 4
Compulsive eating	0 1 2 3 4	0 1 2 3 4
Water retention	0 1 2 3 4	0 1 2 3 4
Underweight	0 1 2 3 4	0 1 2 3 4
<b>WEIGHT Subtotal</b>	_____	_____
<b>OTHER</b>		
Frequent illness	0 1 2 3 4	0 1 2 3 4
Frequent or urgent urination	0 1 2 3 4	0 1 2 3 4
Genital itch or discharge	0 1 2 3 4	0 1 2 3 4
<b>OTHER Subtotal</b>	_____	_____
<b>GRAND TOTAL - add all subtotals for your score</b>	_____	_____

### Key to Toxicity Quiz

Add individual scores and total each group.

Add each group scores and give a grand total.

- Optimal is less than 10
- Mild Toxicity: 10-50
- Moderate Toxicity: 50-100
- Severe Toxicity: over 100