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			
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
EARS Subtotal	_____	_____
EMOTIONS		
Mood swings	0 1 2 3 4	0 1 2 3 4
Anxiety, fear, or nervousness	0 1 2 3 4	0 1 2 3 4
Anger, irritability, or aggressiveness	0 1 2 3 4	0 1 2 3 4
Depression	0 1 2 3 4	0 1 2 3 4
EMOTIONS Subtotal	_____	_____
ENERGY/ACTIVITY		
Fatigue, sluggishness	0 1 2 3 4	0 1 2 3 4
Apathy, lethargy	0 1 2 3 4	0 1 2 3 4
Hyperactivity	0 1 2 3 4	0 1 2 3 4
Restlessness	0 1 2 3 4	0 1 2 3 4
ENERGY/ACTIVITY Subtotal	_____	_____
EYES		
Watery or itchy eyes	0 1 2 3 4	0 1 2 3 4
Swollen, reddened, or sticky eyelids	0 1 2 3 4	0 1 2 3 4
Bags or dark circles under eyes	0 1 2 3 4	0 1 2 3 4
Blurred or tunnel vision (does not include near- or far-sightedness)	0 1 2 3 4	0 1 2 3 4
EYES Subtotal	_____	_____
HEAD		
Headaches	0 1 2 3 4	0 1 2 3 4
Faintness	0 1 2 3 4	0 1 2 3 4

Dizziness	0 1 2 3 4	0 1 2 3 4
Insomnia	0 1 2 3 4	0 1 2 3 4
HEAD Subtotal	_____	_____
HEART		
Irregular or skipped heartbeat	0 1 2 3 4	0 1 2 3 4
Rapid or pounding heartbeat	0 1 2 3 4	0 1 2 3 4
Chest pain	0 1 2 3 4	0 1 2 3 4
HEART Subtotal	_____	_____
JOINTS/MUSCLES		
Pain or aches in joints	0 1 2 3 4	0 1 2 3 4
Arthritis	0 1 2 3 4	0 1 2 3 4
Stiffness or limitation of movement	0 1 2 3 4	0 1 2 3 4
Pain or aches in muscles	0 1 2 3 4	0 1 2 3 4
Feeling of weakness or tiredness	0 1 2 3 4	0 1 2 3 4
JOINTS/MUSCLES Subtotal	_____	_____
LUNGS		
Chest congestion	0 1 2 3 4	0 1 2 3 4
Asthma or bronchitis	0 1 2 3 4	0 1 2 3 4
Shortness of breath	0 1 2 3 4	0 1 2 3 4
Difficulty breathing	0 1 2 3 4	0 1 2 3 4
LUNGS Subtotal	_____	_____
MIND		
Poor memory	0 1 2 3 4	0 1 2 3 4

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

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
SKIN Subtotal	_____	_____
WEIGHT		
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
WEIGHT Subtotal	_____	_____
OTHER		
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
OTHER Subtotal	_____	_____
GRAND TOTAL - add all subtotals for your score	_____	_____

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