BEFORE YOU DETOX

Patient Name: _____ **Date:** _____

Before you begin the Core Restore detoxification program, it is important to first evaluate your current health state. This questionnaire will help identify signs of toxic burden. You will take this questionnaire again in 7 days to evaluate your progress. This will help you and your healthcare provider evaluate your success and continued improvement.

POINT SCALE: 0 = Never 1 = Occasionally 2 = Frequently

Digestive
0 1 2 Bowel movements less than once per day
0 1 2 Bloated feeling
0 1 2 Belching and/or gas
0 1 2 Heartburn
____ **Total**

Head
0 1 2 Headaches
0 1 2 Pressure
0 1 2 Dizziness
0 1 2 Faintness
____ **Total**

Emotions
0 1 2 Mood swings
0 1 2 Feelings of fear and/or nervousness
0 1 2 Anger and/or irritability
0 1 2 Feelings of sadness
____ **Total**

Mind
0 1 2 Poor memory and/or confusion
0 1 2 Difficulty concentrating
0 1 2 Poor coordination
0 1 2 Difficulty making decisions
____ **Total**

Energy & Activity
0 1 2 Fatigue and/or sluggishness
0 1 2 Hyperactivity
0 1 2 Restlessness
0 1 2 Occasional sleeplessness
____ **Total**

Ears
0 1 2 Itchy ears
0 1 2 Earaches
0 1 2 Drainage from ear
0 1 2 Ringing in ears and/or hearing loss
____ **Total**

Eyes
0 1 2 Watery and/or itchy eyes
0 1 2 Swollen and/or reddened eyelids
0 1 2 Dark circles under the eyes
0 1 2 Blurred vision (excluding near- or far-sightedness)
____ **Total**

Nose
0 1 2 Stuffy nose
0 1 2 Sinus congestion
0 1 2 Sneezing
0 1 2 Mucus
____ **Total**

Lungs
0 1 2 Shortness of breath
0 1 2 Difficulty breathing
0 1 2 Chest congestion
____ **Total**

Mouth & Throat
0 1 2 Coughing
0 1 2 Gagging and/or frequent need to clear throat
0 1 2 Hoarseness and/or loss of voice
0 1 2 Dental problems
____ **Total**

Skin
0 1 2 Acne
0 1 2 Hair loss and/or hair thinning
0 1 2 Body odor
0 1 2 Excessive sweating
____ **Total**

Joints & Muscles
0 1 2 Pain or aches in joints and/or lower back
0 1 2 Stiffness and/or limitation in movement
0 1 2 Pain or aches in muscles
0 1 2 Feelings of weakness and/or tiredness
____ **Total**

Heart
0 1 2 Skipped heartbeats
0 1 2 Rapid heartbeats
0 1 2 Chest discomfort
____ **Total**

Weight
0 1 2 Underweight
0 1 2 Overweight
0 1 2 Difficulty losing weight
0 1 2 Crave certain foods
____ **Total**

Other
0 1 2 Food sensitivities
0 1 2 Chemical and/or environmental sensitivities
0 1 2 Frequent and/or urgent urination
0 1 2 Bloating and/or mood swings before menstruation
____ **Total**

Please add the totals from each section and write the section total in the spaces provided. Then, add all the section totals together and put that total in the space below.

GRAND TOTAL _____

INTERPRETING YOUR TOXICITY SCORE:

10 or lower: You have a **low** level of toxic burden
11 to 30: You have a **moderate** level of toxic burden
31 or higher: You have a **high** level of toxic burden

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