SYMPTOMS & TOXICITY

The Toxicity and Symptom Screening Questionnaire assesses symptoms that help to identify the underlying causes of illness, and helps you track your progress over time.

Rate each of the following symptoms based upon your health profile for the **past 14 days.**

_____
Health Care Practitioner

_____
Patient

_____
Date Completed

INSTRUCTIONS

Please review each health score area that corresponds with a health/body area. Write down the corresponding amount of points per item in that area. Once you complete filling out that area, total your point and record it in the TOTAL field. When you come to the end of the survey add up all the totals from each area together to arrive at your GRAND TOTAL. Please record that GRAND TOTAL and submit to your clinician.

HEALTH/BODY AREA POINT SCALE

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

SYMPTOMS & TOXICITY

EAR

- Itchy Ears _____
- Earaches, Ear Infections _____
- Drainage from Ear _____
- Ringing in Ears _____
- Hearing Loss _____
- Red or Burning Ears _____

Total: _____

NOSE

- Stuffy Nose _____
- Sinus Problems _____
- Hay Fever _____
- Sneezing Attacks _____
- Excessive Mucus Formation _____

Total: _____

MOUTH/THROAT

- Chronic Coughing _____
- Gagging, Frequent Need to Clear throat _____
- Sore Throat, Hoarseness, Loss of Voice _____
- Swollen/Discolored Tongue, Gum, Lips _____
- Canker Sores _____
- Cracking at Corner of Lips _____

Total: _____

EYES

- Watery or Itchy Eyes _____
- Swollen, Reddened or Sticky Eyelids _____
- Bags or Dark Circles Under Eyes _____
- Blurred or Tunnel Vision _____
- Floaters _____

Total: _____

HEAD

- Headaches _____
- Faintness _____
- Dizziness _____
- Insomnia _____

Total: _____

SKIN

- Acne _____
- Hives, Rashes or Dry Skin _____
- Hair Loss _____
- Flushing or Hot Flushes _____
- Excessive Sweating _____

Total: _____

SYMPTOMS & TOXICITY

JOINTS/MUSCLES

- Pain or Aches in Joints _____
- Arthritis _____
- Stiffness or Limitation of Movement _____
- Pain or Aches in Muscles _____
- Feeling of Weakness or Tiredness _____
- Pain that Moves from Joint to Joint _____

Total: _____

DIGESTIVE TRACT

- Nausea or Vomiting _____
- Diarrhea _____
- Constipation _____
- Bloated Feeling _____
- Belching or Passing Gas _____
- Heartburn _____
- Intestinal/Stomach Pain _____
- Mucous _____
- Malodorous gas _____

Total: _____

HEART

- Irregular or Skipped Heartbeat _____
- Rapid or Pounding Heartbeat _____
- Chest Pain _____

Total: _____

LUNGS

- Chest Congestion _____
- Asthma, Bronchitis _____
- Shortness of Breath _____
- Difficult Breathing _____

Total: _____

WEIGHT

- Binge Eating/Drinking _____
- Craving Certain Foods _____
- Excessive Weight _____
- Compulsive Eating _____
- Water Retention _____
- Underweight _____

Total: _____

ENERGY/ACTIVITY

- Fatigue, Sluggishness _____
- Apathy, Lethargy _____
- Hyperactivity _____
- Worst with Exercise _____
- Better with Naps _____

Total: _____

SYMPTOMS & TOXICITY

MIND

Poor Memory	_____
Confusion, Poor Comprehension	_____
Poor Concentration	_____
Poor Physical Coordination	_____
Difficulty in Making Decisions	_____
Stuttering or Stammering	_____
Slurred Speech	_____
Learning Disabilities	_____
Total:	_____

EMOTIONS

Mood Swings	_____
Anxiety, Fear or Nervousness	_____
Depression	_____
Total:	_____

OTHER

Frequent Illness	_____
Frequent or Urgent Urination	_____
Genital Itch or Discharge	_____
Total:	_____

Add together the total from each health/body related area and put the number below in the **GRAND TOTAL** field.

GRAND TOTAL: _____

COMPARE YOUR GRAND TOTAL TO THE VALUES BELOW - TOXICITY SCALE

<10	10-50	50-100	100>
OPTIMAL	MILD TOXICITY	MODERATE TOXICITY	SEVERE TOXICITY