

Toxic Screening Test



Rate each of the following symptoms based upon your profile for the past 30 days:

POINT SCALE:

- 0 = never or almost never have the symptom
- 1 = occasionally have it, effect is not severe
- 2 = occasionally have it, effect is severe
- 3 = frequently have it, effect is not severe
- 4 = frequently have it, effect is severe

DIGESTIVE

- ___ Nausea or vomiting
- ___ Diarrhea
- ___ Constipation
- ___ Bloating feeling
- ___ Belching, passing gas
- ___ Heartburn
- ___ **TOTAL**

EARS

- ___ Itchy ears
- ___ Earaches, ear infection
- ___ Drainage from ear
- ___ Ringing in ears hearing loss
- ___ **TOTAL**

EMOTIONS

- ___ Mood swings
- ___ Anxiety, fear, nervousness
- ___ Anger, irritability
- ___ Depression
- ___ **TOTAL**

ENERGY/ACTIVITY

- ___ Fatigue, sluggishness
- ___ Apathy, lethargy
- ___ Hyperactivity
- ___ Restlessness
- ___ **TOTAL**

EYES

- ___ Watery, itchy eyes
- ___ Swollen, reddened or sticky eyelids
- ___ Dark circles under eyes
- ___ Blurred/tunnel vision
- ___ **TOTAL**

HEAD

- ___ Headaches
- ___ Faintness
- ___ Dizziness
- ___ Insomnia feeling
- ___ **TOTAL**

HEART

- ___ Skipped heartbeats
- ___ Rapid heartbeats
- ___ Chest pain
- ___ **TOTAL**

JOINTS/MUSCLES

- ___ Pain or aches in joints
- ___ Arthritis
- ___ Stiffness, limited movement
- ___ Pain, aches in muscles
- ___ Feeling of weakness or tiredness
- ___ **TOTAL**

LUNGS

- ___ Chest congestion
- ___ Asthma, bronchitis
- ___ Shortness of breath
- ___ Difficulty breathing
- ___ **TOTAL**

MIND

- ___ Poor memory
- ___ Confusion
- ___ Poor concentration
- ___ Difficulty making decisions
- ___ Stuttering, stammering
- ___ Slurred speech
- ___ Learning disabilities
- ___ **TOTAL**

MOUTH/THROAT

- ___ Chronic coughing
- ___ Gagging, frequent need to clear throat
- ___ Sore throat, hoarse
- ___ Swollen or discolored tongue, gums lips
- ___ Canker sores
- ___ **TOTAL**

NOSE

- ___ Stuffy nose
- ___ Sinus problems
- ___ Hay fever
- ___ Sneezing attacks
- ___ Excessive mucus
- ___ **TOTAL**

SKIN

- ___ Acne
- ___ Hives, rashes, dry skin
- ___ Hair loss
- ___ Flushing or hot flashes
- ___ Belching, passing gas
- ___ Excessive sweating
- ___ **TOTAL**

WEIGHT

- ___ Binge eating/drinking
- ___ Craving certain foods
- ___ Compulsive eating
- ___ Water retention
- ___ Underweight
- ___ **TOTAL**

OTHER

- ___ Frequent illness
- ___ Frequent or urgent urination
- ___ Genital itch, discharge
- ___ **TOTAL**

Add up the numbers to arrive at a total for each section, then add the totals for each section to arrive at the grand total. If any individual section total is 10 or more, or the grand total is 50 or more, you may benefit from information in the **Home Test pH Kit**. Be sure to check out our personally tested products in our **catalog** as well. No one cares more about your health than you do!

_____ **GRAND TOTAL**