

DETOX QUIZ

For each section circle the number if the answer is yes. Total your yes answers and score 1 point for each yes in sections A and B, 2 points for each yes in section C and record it at the end of the section. Add the totals for each section to get your Grand Total Score.

Section A: Medical History

1. Have you had dental work including any of the following: braces, root canal, fillings, crowns, implants, etc.? (1 point per procedure)
2. Have you experienced any reactions to medical prescriptions?
3. Do you react to anesthesia? Have you had anesthesia in the last 3 years? (1 point per)
4. Have you had cosmetic procedures including botox
5. Do you suffer from depression or memory issues?
6. Do you suffer from fibromyalgia?
7. Do you suffer from psoriasis or eczema?
8. Do you get dermatitis flares of hives, rashes, skin reaction?
9. Do you suffer from arthritis or myopathy aching in joints or muscle?
10. Do you suffer from food sensitivity, gastrointestinal distress, or IBS?
11. Do you suffer from gallbladder or liver related conditions?
12. Are your symptoms worse on rainy, damp, days or in moldy places?
13. Do you have Neuropathy: Numbness, burning, or tingling, “pins and needles” feeling?

Section A Total Yes Answers _____

Section B: Symptoms and Lifestyle

14. Do you regularly consume alcoholic beverages? (score of 1 point for <5 drinks/wk, score of 2 points for >6 drinks/wk)
15. Do you eat processed foods (shelf stable foods with multiple ingredients, preservatives, binders, fillers etc)
16. Do you live in an old home (50 years or more)?
17. Has your home or office had water damage, or have mold or a damp basement?
18. Do you drink faucet/ tap/ unfiltered water?
19. Are you exposed to paints, chemicals, adhesives, insulation/other airborne chemicals?
20. Do you get your hair dyed?
21. Do you get your nails painted or wear nail polish?
22. Do you eat conventional animal products (meat, dairy, etc)
23. Do you smoke? <3 cigarettes/wk 1 point, >4 cigarettes/wk 2 points
24. Are you exposed to fertilizers, pesticides, or other agricultural products?

25. Do you use cleaning products, air fresheners, or disinfectants?
26. Do you eat conventionally grown produce?
27. Are you chronically stressed?
28. Are you often Irritable?
29. Experience muscle aches or pain in joints
30. Do you have frequent headaches?
31. Cold extremities (hands or feet)
32. Do you experience wheezing or shortness of breath?

Section B Total Yes Answers _____

Section C: Symptoms and Lifestyle part 2

33. White or yellow-coated tongue and/or bad breath
34. Fluid retention
35. Sugar cravings
36. Bloating in the belly
37. Stubborn weight loss
38. Excessive sweating or significant cold
39. Constant Foot, body, or hair odor
40. Intolerant to chemicals: drinking alcohol (lightweight) or react to perfumes
41. Chronic fatigue or low energy
42. Brain Fog
43. Moodiness
44. Skin problems: acne, rosacea, rashes
45. IBS issues: Diarrhea or Constipation
46. Auto-immune disease (Hashimotos thyroiditis, Crohn's, MS, Lupus, etc.)
47. Congested sinuses

Section C Total Yes Answers _____ **x2=** _____

Total Score (section A, B, C) _____

The grand total will be used to determine if your system is overburdened with toxins and if your detox glands are overwhelmed. The level of your total will determine how severe the problem may be. Regardless of your score you can benefit from the dietary approaches in this ebook, but a score of 8 or more will require the Detox Support Packs to aid in successful excretion and whole body reset!

Interpretation:

7 or below Toxicity is not likely to cause health problems

8-15 Toxicity is potentially significant

16-20 Toxicity is likely significant

21+ Toxicity is a driving factor in your imbalance