

True Cellular Detox™ Neurotoxic Questionnaire

First Name: _____

Date: _____

Last Name: _____

Current Age: _____

Address: _____

Gender: _____

City: _____

Height: _____

State/Zip: _____

Weight: _____

Email: _____

Name of Practitioner: _____

Phone: _____

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year.

If you cannot answer a question, simply leave it blank.

POINT SCALE:

0 = Never had symptom, 1 = Occasionally have it, mild effect, 2 = Occasionally have it, severe effect,
 3 = Frequently have it, mild effect, 4 = Frequently have it, severe effect

Section 1	NOT SEVERE					VERY SEVERE
Anxiety	0	1	2	3	4	
Mood swings	0	1	2	3	4	
Enraged behavior or anger	0	1	2	3	4	
Excessive shyness, timidity, social phobia (not typical to your personality)	0	1	2	3	4	
Irritability (not typical to your personality)	0	1	2	3	4	
Low body temperature (below 97.3 F)	0	1	2	3	4	
Insomnia (can't get to sleep or return to sleep)	0	1	2	3	4	
Dizziness	0	1	2	3	4	
Sound in ears (ringing or hearing your heart beat)	0	1	2	3	4	
Psychological symptoms, even thoughts of suicide	0	1	2	3	4	
Sensitivity to sound	0	1	2	3	4	

Section 1 total: _____

Section 2	NOT SEVERE					VERY SEVERE
Indecisiveness	0	1	2	3	4	
Feeling of being overwhelmed or fearful	0	1	2	3	4	
Metallic taste in your mouth	0	1	2	3	4	
Bad breath	0	1	2	3	4	
Bleeding gums	0	1	2	3	4	
Sensitive teeth	0	1	2	3	4	
Canker sores or other sores in the mouth	0	1	2	3	4	
Floater, shadows or swimmers when you read or look into the sky	0	1	2	3	4	
Dyslexia or loss of place while reading, even as a child	0	1	2	3	4	
Swelling eyelids	0	1	2	3	4	
Peeling on the top layer of skin (hands, feet)	0	1	2	3	4	
Dry skin	0	1	2	3	4	
Heart pain (angina) and you are under 45 years old	0	1	2	3	4	
Depression	0	1	2	3	4	
Gout (arthritic pain, especially in big toes)	0	1	2	3	4	
Pain in shoulders or upper back	0	1	2	3	4	
Twitching eyelids	0	1	2	3	4	
Anemia	0	1	2	3	4	
Wrist/ankle drop or weak extensor muscles	0	1	2	3	4	
Hair falls out (not normal male pattern baldness)	0	1	2	3	4	

Section 2 total: _____

Section 3:	NOT SEVERE					VERY SEVERE
Sensitivity to light	0	1	2	3	4	
Fatigue after exercising (feeling worse)	0	1	2	3	4	
Bad night vision or seeing halos around lights	0	1	2	3	4	
Shortness of breath, with very little effort	0	1	2	3	4	
Excessive thirst and/or frequent urination	0	1	2	3	4	
Red eyes or tearing	0	1	2	3	4	
Blurred vision at times	0	1	2	3	4	
Morning stiffness	0	1	2	3	4	
Sensitivity to smells (chemicals such as petrochemicals, perfumes, air fresheners)	0	1	2	3	4	
Chronic fatigue or weakness	0	1	2	3	4	
Non-restful sleep	0	1	2	3	4	
Section 3 total: _____						

Section 4	NOT SEVERE					VERY SEVERE
Receive static shock more often & with more dramatic effect than normal	0	1	2	3	4	
Trouble processing new information	0	1	2	3	4	
Word reversal or trouble finding words	0	1	2	3	4	
Sensitivity to touch	0	1	2	3	4	
Short-term memory loss	0	1	2	3	4	
Chronic sinus congestion	0	1	2	3	4	
Dry non-productive cough	0	1	2	3	4	
Muscle twitching	0	1	2	3	4	
Excessive sweating, especially at night	0	1	2	3	4	

Section 4 cont...	NOT SEVERE					VERY SEVERE
Joint pain - not necessarily true arthritis - can move from joint to joint	0	1	2	3	4	
Difficulty losing weight regardless of diet or exercise	0	1	2	3	4	
Persistent fungal or viral infection, including athlete's foot, warts, jock itch, candida	0	1	2	3	4	
Frequent illness, prolonged illness or sick days	0	1	2	3	4	
Numbness or weakness in arms and legs	0	1	2	3	4	
Headaches	0	1	2	3	4	
Trouble adding or dividing numbers in your head	0	1	2	3	4	
Fluctuating constipation and diarrhea	0	1	2	3	4	
Stomach pain for no apparent reason	0	1	2	3	4	
Appetite swings	0	1	2	3	4	
Frequent muscle aches, cramps, unusual sharp sudden pains	0	1	2	3	4	
Rashes or rosacea	0	1	2	3	4	
Cold extremities (hands and feet)	0	1	2	3	4	

Section 4 total: _____

POINT SCALE TOTAL: _____

Notes: