Total Toxic Burden Assessment

NAME:_____ DATE:_____

The goal of the questionnaire is not to act as a substitute for a professionally conducted laboratory screening and assessment, but rather to identify areas in which you can take an aggressive action to improve your health and reduce your toxic load.

DIET

1. How many fast food meals do you eat each week?
   - ☐ (+1) None
   - ☐ (-1) 1-2 meals
   - ☐ (-2) 3 or more meals

2. Do you consume "diet foods" sweetened with aspartame, Splenda or saccharin?
   - ☐ Yes (-1) ☐ No (+1)

3. Are you overweight or do you tend to overeat?
   - ☐ Yes (-1) ☐ No (+1)

4. Do you consume damaged fats? (particularly hydrogenated oils or oxidized/rancid fats)
   - ☐ Yes (-1) ☐ No (+1)

5. Do you regularly consume foods preserved with MSG (monosodium glutamate)?
   - ☐ Yes (-1) ☐ No (+1)

6. Do you eat foods that are artificially colored?
   - ☐ Yes (-1) ☐ No (+1)

7. Do you chew your food completely?
   - ☐ Yes (+1) ☐ No (-1)

8. When do you eat refined carbs or sugar during the day?
   - ☐ (+1) Never
   - ☐ (-1) Morning
   - ☐ (-1) Afternoon
   - ☐ (-1) Evening
   - ☐ (-2) Afternoon & Evening
   - ☐ (-3) Throughout the day

9. Do you eat **non**-organic produce?
   - ☐ Yes (-1) ☐ No (+1)

10. How often do you eat **non**-organic produce?
    - ☐ (+1) Never
    - ☐ (-1) Sometimes
    - ☐ (-2) Always

11. How many different colors of vegetables & fruits do you eat in a day?
    - ☐ (-1) 0-1 different colors
    - ☐ (+1) 2-4 different colors
    - ☐ (+2) 5-7 different colors

12. Do you have an excessive consumption of sodas, coffee (more than two cups a day)?
    - ☐ Yes (-1) ☐ No (+1)

13. Is your coffee and/or tea certified organic?
    - ☐ (+1) Always
    - ☐ (-1) Sometimes
    - ☐ (-2) Never

14. Do you use freshly ground flaxseed meal?
    - ☐ Yes (+1) ☐ No (-1)

15. Is your oil organic and in a dark bottle?
    - ☐ Yes (+1) ☐ No (-1)

16. Do you drink alkaline-type green drinks or chlorella beverages?
    - ☐ Yes (+1) ☐ No (-1)

17. Do you drink 8-10 glasses of filtered, spring or mineral water every day?
    - ☐ Yes (+1) ☐ No (-1)

18. Do you use fresh dark green herbs like cilantro, in your cooking?
    - ☐ Yes (+1) ☐ No (-1)

19. About how many grams of fiber do you eat each day?
    - ☐ (-3) 0 – 10 grams
    - ☐ (-2) 10 – 15 grams
    - ☐ (-1) 15 – 20 grams
    - ☐ (+1) 20 – 25 grams
    - ☐ (+2) 25+ grams

20. Do you cook or re-heat foods in plastic containers in the microwave?
    - ☐ Yes (-1) ☐ No (+1)

21. Do you consistently take high quality antioxidants?
    - ☐ Yes (+1) ☐ No (-1)

22. Do you use whey protein?
    - ☐ Yes (+1) ☐ No (-1)

23. Do you use probiotics or prebiotics?
    - ☐ Yes (+1) ☐ No (-1)

Total Toxic Burden Assessment

LIFESTYLE

25. Do you exercise 2 or more times per week for 30 minutes or more to induce a hard sweat?
☐ Yes (+1) ☐ No (-1)

26. Do you experience GI distress?
☐ Yes (-1) ☐ No (+1)

27. Do you consume alcohol?
☐ No (+1) ☐ Yes (-1) 1-4 drinks per week
☐ Yes (-2) 5 or more drinks per week

28. Do you regularly use over the counter (OTC) medication?
☐ Yes (-1) ☐ No (+1)

29. Do you use nicotine?
☐ Yes (-1) ☐ No (+1)

30. Do you consistently use a sauna?
☐ Yes (+1) ☐ No (-1)

31. Are you taking any medication on a daily basis?
☐ Yes (-1) ☐ No (+1)

32. For women, is your body fat 30% or greater?
☐ Yes (-1) ☐ No (+1)

33. For men, is your body fat 20% or greater?
☐ Yes (-1) ☐ No (+1)

ENVIRONMENT

34. Do you use a cell phone without a headset or hands free?
☐ Yes (+1) ☐ No (-1)

35. Do you live or work in an environment that re-circulates the indoor air?
☐ Yes (-1) ☐ No (+1)

36. Do you use pesticides on your property?
☐ Yes (-1) ☐ No (+1)

37. How often do you travel by plane?
☐ (+2) Never
☐ (+1) 1-3 times a year
☐ (-1) 4-6 times a year
☐ (-2) 6 or more times a year

38. Do you use a computer?
☐ Yes (-1) ☐ No (+1)

39. How many hours a day do you spend in front of a computer?
☐ (+1) Less than a ½ hour .
☐ (-1) 1-2 hours
☐ (-2) 3-6 hours
☐ (-3) 7 or more hours

40. Do you live with someone who uses nicotine?
☐ Yes (-1) ☐ No (+1)

41. Do you have green plants in your house?
☐ Yes (+1) ☐ No (-1)

42. Do you expose yourself to toxins like traditional household cleaners?
☐ Yes (-1) ☐ No (+1)

43. Do you consistently use air purifiers?
☐ Yes (+1) ☐ No (-1)

44. Do you use water filters?
☐ (-2) Never
☐ (-1) Sometimes
☐ (+1) Always

Add up your responses, and refer to the scoring below: _____ Total Score

This assessment will help identify the areas that need your attention. Please review and consider all of your responses that did not have a **(+)** response; each **(-)** answer for the above questions means you have increased risk of a toxic overload. There are many simple actions you and your healthcare provider can take to measure your specific toxic load and aid in determining which treatment would be most effective for you.