

## STEPS TO OPTIMAL HEALTH

- What is Health?
- How do you know if you are Healthy?
- What is the first step to optimal health?
- Patterns/Habits to Optimal Health
  1. Refreshing Water
  2. Breath of Life Breakfast
  3. Energizing Exercise
  4. Lunching Naturally
  5. Meal Prep
  6. Designing Dinner
  7. Sweets and Deserts
  8. Digestion NOT IN-digestion
  9. Oils and Toils
  10. Optimal Health for Women
  11. Optimal Health for Men
  12. Optimal Health for Children
  13. Warranty Work
  14. Body Building from the Inside Out
  15. Restful; Peaceful Sleep
  16. "Saw" Sharpening
  17. Time for HIM/Relationship Renewal

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Dr. Bob is available to speak at your business and/or organization. Live or on the WEB!!

# Toxicity Questionnaire

## Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or never experience the symptom
1	Occasionally experience the symptom; Effect is not severe
2	Occasionally experience the symptom; Effect is severe
3	Frequently experience the symptom; Effect is not severe
4	Frequently experience the symptom; Effect is severe

### 1. DIGESTIVE

- a. Nausea and/or vomiting 0 1 2 3 4  
 b. Diarrhea 0 1 2 3 4  
 c. Constipation 0 1 2 3 4  
 d. Bloating feeling 0 1 2 3 4  
 e. Belching and/or passing gas 0 1 2 3 4  
 f. Heartburn 0 1 2 3 4

**Total:** \_\_\_\_\_

### 2. EARS

- a. Itchy ears 0 1 2 3 4  
 b. Earaches, ear infections 0 1 2 3 4  
 c. Drainage from ear 0 1 2 3 4  
 d. Ringing in ears, hearing loss 0 1 2 3 4

**Total:** \_\_\_\_\_

### 3. EMOTIONS

- a. Mood swings 0 1 2 3 4  
 b. Anxiety, fear, nervousness 0 1 2 3 4  
 c. Anger, irritability 0 1 2 3 4  
 d. Depression 0 1 2 3 4  
 e. Sense of despair 0 1 2 3 4  
 f. Apathy / lethargy 0 1 2 3 4

**Total:** \_\_\_\_\_

### 4. ENERGY / ACTIVITY

- a. Fatigue / sluggishness 0 1 2 3 4  
 b. Hyperactivity 0 1 2 3 4  
 c. Restlessness 0 1 2 3 4  
 d. Insomnia 0 1 2 3 4  
 e. Startled awake at night 0 1 2 3 4

**Total:** \_\_\_\_\_

### 5. Eyes

- a. Watery, itchy eyes 0 1 2 3 4  
 b. Swollen/reddened/sticky eyelids 0 1 2 3 4  
 c. Dark circles under eyes 0 1 2 3 4  
 d. Blurred / tunnel vision 0 1 2 3 4

**Total:** \_\_\_\_\_

### 6. HEAD

- a. Headaches 0 1 2 3 4  
 b. Faintness 0 1 2 3 4  
 c. Dizziness 0 1 2 3 4  
 d. Pressure 0 1 2 3 4

**Total:** \_\_\_\_\_

### 7. LUNGS

- a. Chest congestion 0 1 2 3 4  
 b. Asthma, Bronchitis 0 1 2 3 4  
 c. Shortness of breath 0 1 2 3 4  
 d. Difficulty breathing 0 1 2 3 4

**Total:** \_\_\_\_\_

### 8. MIND

- a. Poor memory 0 1 2 3 4  
 b. Confusion 0 1 2 3 4  
 c. Poor concentration 0 1 2 3 4  
 d. Poor coordination 0 1 2 3 4  
 e. Difficulty making decisions 0 1 2 3 4  
 f. Stuttering, stammering 0 1 2 3 4  
 g. Slurred speech 0 1 2 3 4  
 h. Learning disabilities 0 1 2 3 4

**Total:** \_\_\_\_\_

### 9. MOUTH / THROAT

- a. Chronic coughing 0 1 2 3 4  
 b. Gagging, frequent need to clear throat 0 1 2 3 4  
 c. Swollen or discolored tongue, ums, lips 0 1 2 3 4  
 d. Canker sores 0 1 2 3 4

**Total:** \_\_\_\_\_

### 10. NOSE

- a. Stuffy nose 0 1 2 3 4  
 b. Sinus problems 0 1 2 3 4  
 c. Hay fever 0 1 2 3 4  
 d. Sneezing attacks 0 1 2 3 4  
 e. Excessive mucous 0 1 2 3 4

**Total:** \_\_\_\_\_

### 11. SKIN

- a. Acne 0 1 2 3 4  
 b. Hives, rashes, dry skin 0 1 2 3 4  
 c. Hair loss 0 1 2 3 4  
 d. Flushing 0 1 2 3 4  
 e. Excessive sweating 0 1 2 3 4

**Total:** \_\_\_\_\_

### 12. HEART

- a. Skipped heartbeats 0 1 2 3 4  
 b. Rapid heartbeats 0 1 2 3 4  
 c. Chest pain 0 1 2 3 4

**Total:** \_\_\_\_\_

### 13. JOINTS / MUSCLES

- a. Pain or aches in joints 0 1 2 3 4  
 b. Rheumatoid arthritis 0 1 2 3 4  
 c. Osteoarthritis 0 1 2 3 4  
 d. Stiffness, limited movement 0 1 2 3 4  
 e. Pain, aches in muscles 0 1 2 3 4  
 f. Recurrent back aches 0 1 2 3 4  
 g. Feeling of weakness/tiredness 0 1 2 3 4

**Total:** \_\_\_\_\_

### 14. WEIGHT

- a. Binge eating / drinking 0 1 2 3 4  
 b. Craving certain foods 0 1 2 3 4  
 c. Excessive weight 0 1 2 3 4  
 d. Compulsive eating 0 1 2 3 4  
 e. Water retention 0 1 2 3 4  
 f. Underweight 0 1 2 3 4

**Total:** \_\_\_\_\_

### 15. OTHER

- a. Frequent illness 0 1 2 3 4  
 b. frequent or urgent urination 0 1 2 3 4  
 c. leaky bladder 0 1 2 3 4  
 d. genital itch, discharge 0 1 2 3 4

**Total:** \_\_\_\_\_

**Section I Total:** \_\_\_\_\_

## Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

<b>16.</b> Circle the corresponding number for questions 16a – 16f below.				
<b>0 Never</b>	<b>1 Rarely</b>	<b>2 Monthly</b>	<b>3 Weekly</b>	<b>4 Daily</b>
a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven & drain cleaners, furniture polish, floor wax, window cleaners, etc.)				0 1 2 3 4
b. How often are pesticides used in your home?				0 1 2 3 4
c. How often do you have your home treated for insects?				0 1 2 3 4
d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office?				0 1 2 3 4
e. How often are you exposed to nail polish, perfume, hair spray, and other cosmetics?				0 1 2 3 4
f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?				0 1 2 3 4
				<b>Total:</b> _____

<b>17.</b> Circle the corresponding number for questions 17a – 17b below.			
<b>0 No</b>	<b>1 Mild Change</b>	<b>2 Moderate Change</b>	<b>3 Drastic Change</b>

a. Have you noticed any negative change in your health since you moved into your home or apartment?					0 1 2 3
b. Have you noticed any negative change in your health since you started your new job?					0 1 2 3
				<b>Total:</b> _____	

<b>18.</b> Answer “Yes” or “No” and circle the corresponding number for questions 18a – 18d below.		
	No	Yes
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2
		<b>Total:</b> _____

**Section II Total:** \_\_\_\_\_

<b>GRAND TOTAL (Section I &amp; Section II)</b>	_____
<p>Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the Grand Total is 40 or more, you may benefit from a Clinical Purification™ program.</p>	

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