True Cellular Detox™

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: ________

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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
Floaters, 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: _________

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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

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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,	0	1	2	3	4
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:

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