Vibrant Wellcare

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Toxicity Evaluation

Point Scale
0= Never, or almost never have the symptom
1= Occasionally have it, effect is not severe
2= Occasionally have it, effect is severe
3= Frequently have it, effect is not severe
4= Frequently have it, effect is severe

Section I - Symptom Evaluation
Rate the following symptoms using the numbered scale above and total for each group.

DIGESTIVE
A. Nausea and/or vomiting _____
B. Diarrhea _____
C. Constipation _____
D. Bloated feeling _____
E. Belching and/or passing gas _____
F. Heartburn _____
Total: _____

EARS
A. Itchy ears _____
B. Earaches or ear infections _____
C. Drainage from ear _____
D. Ringing in ears or hearing loss _____
Total: _____

HEAD
A. Headaches _____
B. Faintness _____
C. Dizziness _____
D. Pressure _____
Total: _____

LUNGS
A. Chest congestion _____
B. Asthma or bronchitis _____
C. Shortness of breath _____
D. Difficulty breathing _____
Total: _____

MIND
A. Poor memory _____
B. Confusion _____
C. Poor concentration _____
D. Poor coordination _____
E. Difficulty making decisions _____
F. Stuttering, stammering _____
G. Slurred speech _____
H. Learning disabilities _____
Total: _____

MOUTH/THROAT
A. Chronic coughing _____
B. Gagging or frequent clearing throat _____
C. Swollen/discolored tongue, gums, lips _____
D. Canker sores _____
Total: _____

SKIN
A. Acne _____
B. Hives, rashes, or dry skin _____
C. Hair loss _____
D. Flushing _____
E. Excessive sweating _____
Total: _____

HEART
A. Skipped heartbeats _____
B. Rapid heartbeats _____
C. Chest pain _____
Total: _____

JOINTS / MUSCLES
A. Pain or aches in joints _____
B. Rheumatoid arthritis _____
C. Osteoarthritis _____
D. Stiffness or limited movement _____
Total: _____

EYES
A. Watery or itchy eyes _____
B. Swollen, reddened, or sticky eyelids _____
C. Dark circles under eyes _____
D. Blurred or tunnel vision _____
E. Pain or aches in muscles _____
F. Recurrent back aches _____
G. Feeling of weakness or tiredness _____
Total:

EMOTIONS
A. Mood swings _____
B. Anxiety, fear, or nervousness _____
C. Anger, irritability _____
D. Depression _____
E. Sense of despair _____
F. Uncaring or disinterested _____
Total: _____

ENERGY / ACTIVITY
A. Fatigue or sluggishness _____
B. Hyperactivity _____
C. Restlessness d.Insomnia _____
D. Startled awake at night _____
Total: _____

WEIGHT
A. Binge eating or drinking _____
B. Craving certain foods _____
C. Excessive weight _____
D. Compulsive eating _____
E. Water retention _____
F. Underweight _____
Total: _____

OTHER
A. Frequent illness _____
B. Frequent or urgent urination _____
C. Leaky bladder _____
D. Genital itch, discharge _____
Total: _____

NOSE
A. Stuffy nose _____
B. Sinus problems _____
C. Hay fever _____
D. Sneezing attacks _____
E. Excessive mucous _____
Total: _____

Add up all the numbers you recorded. Section I - Symptom Evaluation Total: _____

Section II: Risk of Exposure
Rate each of the following situations based upon your environmental profile for the past 120 days.

0-Never 1-Rarely 2-Monthly 3-Weekly 4-Daily

A. ____ How often are strong chemicals used in your home?(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.)
B. ____ How often are pesticides used in your home?
C. ____ How often do you have your home treated for insects?
D. ____ How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office?
E. ____ How often are you exposed to nail polish, perfume, hairspray, or other cosmetics?
F. ____ How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?

Rate each of the following based on your experience using the scale below.

0 No 1 Mild Change 2 Moderate Change 3 Drastic Change

A. ____ Have you noticed any negative change in your health since you moved into your home or apartment?
B. ____ Have you noticed any change in your health since you started your new job?
C. ____ Do you have a water purification system in your home?
D. ____ Do you have any indoor pets?
E. ____ Do you have an air purification system in your home?
F. ____ Are you a dentist, painter, farm worker, or construction worker?
Total:

Add up all the numbers you recorded. Section II Total: _____

Grand Total (Section I & Section II) _____

If any individual group total is 6 or more, or the grand total is 40 or more, you may benefit from a purification program.