

# QUESTIONNAIRE

The following questionnaire asks you to evaluate a number of mental, physical and dental symptoms that you may be experiencing, or suffer from time to time, and has been compiled so that your physician and dentist can assess your potential body-burden of stored heavy metal toxins. Mercury, lead, cadmium arsenic and aluminum is the most common. The combination and synergism of these metals can produce toxicity that varies from patient to patient, and depends on one's genetic ability to excrete these toxins. For evaluation by your physician and dentist, this baseline record is needed to monitor and measure your progress as you detoxify.

Name \_\_\_\_\_

Today's Date \_\_\_\_\_

Address \_\_\_\_\_

Telephone ( ) \_\_\_\_\_

Date of Birth \_\_\_\_\_

OFFICE USE				
Hg:	Al:	Tl:	Cd:	Cs:
Pb:	As:	Sn:	Ni:	

Check the appropriate box(es) if you have ever suffered from the following symptoms:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Bleeding gums  | <input type="checkbox"/> Irritability                                      | <input type="checkbox"/> Inability to concentrate  | <input type="checkbox"/> Dry Mouth            |
| <input type="checkbox"/> Bone loss around teeth                                       | <input type="checkbox"/> Anxiety / nervousness                             | <input type="checkbox"/> Difficulty making decisions                                     | <input type="checkbox"/> Loss of coordination |
| <input type="checkbox"/> Loose teeth  | <input type="checkbox"/> Difficulty breathing when anxious                 | <input type="checkbox"/> Lethargy/drowsiness   | <input type="checkbox"/> Loss of balance      |
| <input type="checkbox"/> Excessive salivation   | <input type="checkbox"/> Restlessness                                      | <input type="checkbox"/> Hallucinations  | <input type="checkbox"/> Abdominal cramps     |
| <input type="checkbox"/> Foul breath  | <input type="checkbox"/> Mood swings                                       | <input type="checkbox"/> Muscle weakness   | <input type="checkbox"/> Stomach problems     |
| <input type="checkbox"/> Metallic taste with certain foods                            | <input type="checkbox"/> Exaggerated response to stimulation               | <input type="checkbox"/> Mental depression/despondency                                   | <input type="checkbox"/> Low blood pressure   |
| <input type="checkbox"/> Tremors/ trembling of hands<br>Feet, lips, eyelids or tongue | <input type="checkbox"/> Fits of anger with violent, irrational<br>conduct | <input type="checkbox"/> Insomnia  | <input type="checkbox"/> High blood pressure  |
| <input type="checkbox"/> Burning sensation of lips/face                               | <input type="checkbox"/> Fearfulness                                       | <input type="checkbox"/> Rocking movements   | <input type="checkbox"/> Increased heart rate |
| <input type="checkbox"/> Burning throat   | <input type="checkbox"/> Lack of self-control                              | <input type="checkbox"/> Frequent leg cramps   | <input type="checkbox"/> Hearing difficulties |
| <input type="checkbox"/> Inflammation of mouth lining                                 | <input type="checkbox"/> Hopelessness                                      | <input type="checkbox"/> Diminished touch sensation                                      | <input type="checkbox"/> Ringing in ears      |
| <input type="checkbox"/> Ulcers in mouth or tongue                                    | <input type="checkbox"/> Loss of self-confidence                           | <input type="checkbox"/> Numbness and tingling of hands,<br>Feet, fingers, toes or lips  | <input type="checkbox"/> Hearing loss         |
| <input type="checkbox"/> Twitching or jerking of muscles                              | <input type="checkbox"/> Suicidal thoughts                                 | <input type="checkbox"/> Aversion to touch   | <input type="checkbox"/> Excessive itching    |
| <input type="checkbox"/> Difficulty walking   | <input type="checkbox"/> Shyness or timidity                               | <input type="checkbox"/> Loss of short-term memory                                       | <input type="checkbox"/> Blurred vision       |
| <input type="checkbox"/> Difficulty talking   | <input type="checkbox"/> Difficulty swallowing                             | <input type="checkbox"/> Easily embarrassed  | <input type="checkbox"/> Allergies            |
| <input type="checkbox"/> Sensitivity to light   | <input type="checkbox"/> Chronic headaches                                 | <input type="checkbox"/> Cold clammy skin- especially<br>Hands and feet                  | <input type="checkbox"/> Sudden hair loss     |
| <input type="checkbox"/> Food sensitivity to eggs or milk                             | <input type="checkbox"/> General food sensitivities                        | <input type="checkbox"/> Skin irritation   | <input type="checkbox"/> General fatigue      |
| <input type="checkbox"/> Frequent or recurring heartburn                              | <input type="checkbox"/> Constant bloated feeling                          | <input type="checkbox"/> Low body temperature  | <input type="checkbox"/> Nausea               |
| <input type="checkbox"/> Frequent urination during the<br>Night                       | <input type="checkbox"/> Menstrual pains                                   | <input type="checkbox"/> Skin rashes   | <input type="checkbox"/> Vomiting             |
| <input type="checkbox"/> Chronic diarrhea/constipation                                | <input type="checkbox"/> Disturbances in menstrual cycle                   | <input type="checkbox"/> Excessive perspiration w/<br>Frequent night sweats              | <input type="checkbox"/> Loss of appetite     |
| <input type="checkbox"/> Unexplained numbness or<br>Burning sensations                | <input type="checkbox"/> Constant or frequent joint pain                   | <input type="checkbox"/> Low blood sugar   | <input type="checkbox"/> Anorexia             |
| <input type="checkbox"/> Slurred speech   | <input type="checkbox"/> Speech disorders                                  | <input type="checkbox"/> Poor performance with timed<br>Tests performed by a neurologist | <input type="checkbox"/> Weight loss          |

Thank you for filling in this questionnaire. In 3-6 months, we will repeat the same exercise – hopefully with fewer check marks.  
The nutritional protocol you will be following, will change depending on your individual response.