**Illness to Wellness**

**Cellular Detoxification**

Neuro-Toxic Questionnaire (NTQ)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brief description of your symptoms and your main complaints:

**Please rate each of the following items based on your typical health profile over the past year. In case you are not sure of answering some of the questions, please leave them blank.**

**Point Scale:**

**0 = Never had the symptom**

**1 = Occasionally having the symptom (Mild effect)**

**2 = Occasionally having the symptom (Severe effect)**

**3 = Frequently having the symptom (Mild effect)**

**4 = Frequently having the symptom (Severe effect)**

**Section 1 Not Severe to Very Severe**

Anxiety 0 1 2 3 4

Mood swings 0 1 2 3 4

Enraged behavior or anger

Excessive shyness, timidity, social phobia 0 1 2 3 4

(not typical to your personality)

Irritability (not typical of 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:** \_\_\_\_\_\_\_\_\_\_

**Section 2 Not Severe to 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

Floater, shadows or swimmers when you read or look to sky 0 1 2 3 4

Dyslexia or loss of place while reading 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 toe) 0 1 2 3 4

Pain in shoulders or in 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 patterned baldness) 0 1 2 3 4

**Section 2 total: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section 3 Not Severe to 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 smell 0 1 2 3 4

(chemicals such as petrochemicals, perfumes, air fresheners)

Chronic fatigue or weakness 0 1 2 3 4

Non-restful sleep 0 1 2 3 4

**Section 3 total: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section 4 Not Severe to Very Severe**

Receive static shock more often, 0 1 2 3 4

and with more dramatic effect than normal

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

Joint pain- not necessarily true arthritis 0 1 2 3 4

Can move from joint to joint

Difficulty losing weight, regardless of diet or exercise 0 1 2 3 4

Persistent fungal or viral infections, 0 1 2 3 4

Including athlete’s foot, warts, jock itch

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 number 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 pains0 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**