

BEFORE YOU DETOX



Patient Name: _____ Date: _____

Before you begin the Core Restore detoxification program, it is important to first evaluate your current health state. This questionnaire will help identify signs of toxic burden. You will take this questionnaire again in 7 days to evaluate your progress. This will help you and your healthcare provider evaluate your success and continued improvement.

POINT SCALE: 0 = Never 1 = Occasionally 2 = Frequently

Digestive

- 0 1 2 Bowel movements less than once per day
- 0 1 2 Bloating feeling
- 0 1 2 Belching and/or gas
- 0 1 2 Heartburn

____ Total

Head

- 0 1 2 Headaches
- 0 1 2 Pressure
- 0 1 2 Dizziness
- 0 1 2 Faintness

____ Total

Emotions

- 0 1 2 Mood swings
- 0 1 2 Feelings of fear and/or nervousness
- 0 1 2 Anger and/or irritability
- 0 1 2 Feelings of sadness

____ Total

Mind

- 0 1 2 Poor memory and/or confusion
- 0 1 2 Difficulty concentrating
- 0 1 2 Poor coordination
- 0 1 2 Difficulty making decisions

____ Total

Energy & Activity

- 0 1 2 Fatigue and/or sluggishness
- 0 1 2 Hyperactivity
- 0 1 2 Restlessness
- 0 1 2 Occasional sleeplessness

____ Total

Ears

- 0 1 2 Itchy ears
- 0 1 2 Earaches
- 0 1 2 Drainage from ear
- 0 1 2 Ringing in ears and/or hearing loss

____ Total

Eyes

- 0 1 2 Watery and/or itchy eyes
- 0 1 2 Swollen and/or reddened eyelids
- 0 1 2 Dark circles under the eyes
- 0 1 2 Blurred vision
(excluding near- or far-sightedness)

____ Total

Nose

- 0 1 2 Stuffy nose
- 0 1 2 Sinus congestion
- 0 1 2 Sneezing
- 0 1 2 Mucus

____ Total

Lungs

- 0 1 2 Shortness of breath
- 0 1 2 Difficulty breathing
- 0 1 2 Chest congestion

____ Total

Mouth & Throat

- 0 1 2 Coughing
- 0 1 2 Gagging and/or frequent need to clear throat
- 0 1 2 Hoarseness and/or loss of voice
- 0 1 2 Dental problems

____ Total

Skin

- 0 1 2 Acne
- 0 1 2 Hair loss and/or hair thinning
- 0 1 2 Body odor
- 0 1 2 Excessive sweating

____ Total

Joints & Muscles

- 0 1 2 Pain or aches in joints and/or lower back
- 0 1 2 Stiffness and/or limitation in movement
- 0 1 2 Pain or aches in muscles
- 0 1 2 Feelings of weakness and/or tiredness

____ Total

Heart

- 0 1 2 Skipped heartbeats
- 0 1 2 Rapid heartbeats
- 0 1 2 Chest discomfort

____ Total

Weight

- 0 1 2 Underweight
- 0 1 2 Overweight
- 0 1 2 Difficulty losing weight
- 0 1 2 Crave certain foods

____ Total

Other

- 0 1 2 Food sensitivities
- 0 1 2 Chemical and/or environmental sensitivities
- 0 1 2 Frequent and/or urgent urination
- 0 1 2 Bloating and/or mood swings before menstruation

____ Total

Please add the totals from each section and write the section total in the spaces provided. Then, add all the section totals together and put that total in the space below.

GRAND TOTAL _____

INTERPRETING YOUR TOXICITY SCORE:

10 or lower: You have a **low** level of toxic burden

11 to 30: You have a **moderate** level of toxic burden

31 or higher: You have a **high** level of toxic burden

AFTER YOU DETOX



Patient Name: _____ **Date:** _____

Congratulations on completing the 7-day Core Restore detoxification program! Hopefully you are feeling more energized and have made a commitment to eating right and making healthier lifestyle choices. Let's evaluate your progress using Core Restore. Your health care professional may use this as a tool to help determine if you should continue with a longer detoxification protocol.

POINT SCALE: 1 = Better 0 = No Change -1 = Worse

Digestive

- 1 0 -1 Bowel movements less than once per day
- 1 0 -1 Bloating feeling
- 1 0 -1 Belching and/or gas
- 1 0 -1 Heartburn

____ **Total**

Head

- 1 0 -1 Headaches
- 1 0 -1 Pressure
- 1 0 -1 Dizziness
- 1 0 -1 Faintness

____ **Total**

Emotions

- 1 0 -1 Mood swings
- 1 0 -1 Feelings of fear and/or nervousness
- 1 0 -1 Anger and/or irritability
- 1 0 -1 Feelings of sadness

____ **Total**

Mind

- 1 0 -1 Poor memory and/or confusion
- 1 0 -1 Difficulty concentrating
- 1 0 -1 Poor coordination
- 1 0 -1 Difficulty making decisions

____ **Total**

Energy & Activity

- 1 0 -1 Fatigue and/or sluggishness
- 1 0 -1 Hyperactivity
- 1 0 -1 Restlessness
- 1 0 -1 Occasional sleeplessness

____ **Total**

Ears

- 1 0 -1 Itchy ears
- 1 0 -1 Earaches
- 1 0 -1 Drainage from ear
- 1 0 -1 Ringing in ears and/or hearing loss

____ **Total**

Eyes

- 1 0 -1 Watery and/or itchy eyes
- 1 0 -1 Swollen and/or reddened eyelids
- 1 0 -1 Dark circles under the eyes
- 1 0 -1 Blurred vision
(excluding near- or far-sightedness)

____ **Total**

Nose

- 1 0 -1 Stuffy nose
- 1 0 -1 Sinus congestion
- 1 0 -1 Sneezing
- 1 0 -1 Mucus

____ **Total**

Lungs

- 1 0 -1 Shortness of breath
- 1 0 -1 Difficulty breathing
- 1 0 -1 Chest congestion

____ **Total**

Mouth & Throat

- 1 0 -1 Coughing
- 1 0 -1 Gagging and/or frequent need to clear throat
- 1 0 -1 Hoarseness and/or loss of voice
- 1 0 -1 Dental problems

____ **Total**

Skin

- 1 0 -1 Acne
- 1 0 -1 Hair loss and/or hair thinning
- 1 0 -1 Body odor
- 1 0 -1 Excessive sweating

____ **Total**

Joints & Muscles

- 1 0 -1 Pain or aches in joints and/or lower back
- 1 0 -1 Stiffness and/or limitation in movement
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- 1 0 -1 Feelings of weakness and/or tiredness

____ **Total**

Heart

- 1 0 -1 Skipped heartbeats
- 1 0 -1 Rapid heartbeats
- 1 0 -1 Chest discomfort

____ **Total**

Weight

- 1 0 -1 Underweight
- 1 0 -1 Overweight
- 1 0 -1 Difficulty losing weight
- 1 0 -1 Crave certain foods

____ **Total**

Other

- 1 0 -1 Food sensitivities
- 1 0 -1 Chemical and/or environmental sensitivities
- 1 0 -1 Frequent and/or urgent urination
- 1 0 -1 Bloating and/or mood swings before menstruation

____ **Total**

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GRAND TOTAL _____



INTERPRETING YOUR SCORE:

10 or higher: You have made steady improvements and reduced your toxic burden. To maintain these positive changes, set a time with your health care provider to detox again. My next scheduled detox will be ____/____/____.

0 to 10: You have made moderate improvements to your toxic burden. Your healthcare provider may recommend that you continue the detoxification for an additional period of time (Level 2 detoxification).

0 or lower: Your healthcare provider may utilize additional nutritional supplementation based on their assessment, and may recommend further testing to uncover any hidden GI conditions.