Toxic Metals Questionnaire
Detox Support Protocol

NAME _____ DATE _____

Mercury Toxicity

	Never	Occasionally	Often	Regularly
Do you have amalgam (silver) fillings in your teeth?	N		Y	20
Have you ever had an amalgam removed?	N		Y	12
If you had amalgams removed, was it done by a biological dentist using a safe protocol?	20 N		Y	4
Were there amalgam fillings in your mother's mouth while she was pregnant with you?	N		Y	3
Have you worked in a dental office?	0	1	2	3
Did you wear contact lenses during the 1980s or early 1990s?	0	1	2	3
Did you take oral contraceptives during the 1980s or early 1990s?	0	1	2	3
Have you had flu shots?	0	1	2	3
Have you had allergy shots?	0	1	2	3
Do you eat Atlantic salmon, shark, swordfish, or tuna more than twice per week?	0	1	2	3
Do you urinate frequently (during the day, night, or both)?	0	1	2	3
Do you have trouble sleeping?	0	1	2	3
Do you have compact fluorescent (CFL) bulbs in your home?	N		Y	6
Have you broken any CFL bulbs? (reference) 	N		Y	12
Do you experience anxiety?	0	1	2	3
Do you experience mood swings?	0	1	2	3
Do you experience anger for no apparent reason?	0	1	2	3
Are you experiencing excessive shyness, timidity, or social phobia (not typical to your personality)?	0	1	2	3
Are you experiencing irritability (not typical to your personality)?	0	1	2	3
Do you get dizzy or have balance issues?	0	1	2	3
Do you experience insomnia (can't get to sleep or return to sleep)?	0	1	2	3
Do you have a low body temperature (below 97.5 degrees Fahrenheit or 36.4 degrees Celsius)?	0	1	2	3
Do you notice sounds in your ears (ringing or hearing your heartbeat)?	0	1	2	3
Are you sensitive to noise?	0	1	2	3
Do you get psychological symptoms, even thoughts of suicide?	0	1	2	3
Mercury Toxicity Total				_____

GREEN	YELLOW	RED
0-30	31-64	65-130

Instructions

Rate each of the questions to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number provided next to your answer. Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

Toxic Metals Questionnaire
Detox Support Protocol

NAME _____ DATE _____

Lead Toxicity

	Never	Occasionally	Often	Regularly
Have you lived in a home built before 1978 using lead-based paint?	0	2	4	6
Have you done any home renovation, including sandblasting or moving walls?	0	2	4	6
Do you currently live or previously lived in a mining community or area?	0	2	4	6
Are you involved in construction, metal salvage, stained glass, or soldering?	0	2	4	6
Are you an electrician, or do you handle ballasts, electrical devices, electrical wiring, or TV glass?	0	2	4	6
Do you paint or handle/make brass, bronze, ceramics, or crystal?	0	2	4	6
Do you handle or reload ammunition?	0	2	4	6
Did you read the newspaper regularly before 1985?	0	2	4	6
Have you previously or do you currently consume a coral calcium supplement?	0	2	4	6
Do you wear lipstick?	0	2	4	6
Have you previously worn or do you currently wear eye cosmetics containing kohl (a dark pigment that's not FDA-approved for makeup)?	0	2	4	6
Are you around or have a significant amount of fake leather or vinyl?	0	2	4	6
Do you get your hair colored?	0	2	4	6
Do you get stomach aches in the morning?	0	1	2	3
Do you experience eyelid swelling?	0	1	2	3
Do your eyelids twitch?	0	1	2	3
Do you get chest or heart pain?	0	1	2	3
Do you get a metallic taste in your mouth?	0	1	2	3
Do you have teeth sensitivity?	0	1	2	3
Do you get bleeding gums?	0	1	2	3
Do you have high blood pressure?	0	1	2	3
Are you indecisive/unable to make decisions?	0	1	2	3
Do you get overwhelmed or fearful?	0	1	2	3
Do you have anemia (low iron/hemoglobin on blood test)?	0	1	2	3
Does your top layer of skin peel (hands, feet)?	0	1	2	3
Do you get dry skin?	0	1	2	3
Do you experience depression?	0	1	2	3
Do you have dyslexia or lose your place while reading, even as a child?	0	1	2	3
Do you have gout (arthritic pain, especially in big toes)?	0	1	2	3

Lead Toxicity Total _____

GREEN	YELLOW	RED
0-37	38-65	66-126