DR. JOEY JONES

Nutrition Patient Information

Once completed, please return to **info@drjoeyjones.com**.

DEMOGRAPHIC INFORMATION

Date ___________________

Last Name ________________________________ Legal First Name ___________________________________

Birth Date ____________ Preferred Name (Optional) ____________________ Age _______ M or F (circle)

CONTACT INFORMATION

Address ____

City ________________________________ State ________ Zip ____________________

Email____

Home Phone ☐ _____________ Work Phone ☐ __________________Cell Phone ☐ __________________

(Please check preferred method of contact)

Toxicity Questionnaire

NAME ______________________ DATE __________

SECTION I - SYMPTOMS

Circle the corresponding number to describe the frequency and severity of the symptom.
Rate each of the following based upon your health profile for the past 90 days.

0	1	2	3	4
Rarely *or Never*	Occasionally *Effect is Not Severe*	Occasionally *Effect is Severe*	Frequently *Effect is Not Severe*	Frequently *Effect is Severe*

Digestive

Nausea and/or Vomiting	0	1	2	3	4
Diarrhea	0	1	2	3	4
Constipation	0	1	2	3	4
Bloated Feeling	0	1	2	3	4
Belching and/or Passing Gas	0	1	2	3	4
Heartburn	0	1	2	3	4

TOTAL ________

Ears

Itchy Ears	0	1	2	3	4
Earaches or Ear Infections	0	1	2	3	4
Drainage from Ear	0	1	2	3	4
Ringing in Ears or Hearing Loss	0	1	2	3	4

TOTAL ________

Emotions

Mood Swings	0	1	2	3	4
Anxiety, Fear, or Nervousness	0	1	2	3	4
Anger, Irritability	0	1	2	3	4
Depression	0	1	2	3	4
Sense of Despair	0	1	2	3	4
Uncaring or Disinterested	0	1	2	3	4

TOTAL ________

Energy / Activity

Fatigue or Sluggishness	0	1	2	3	4
Hyperactivity	0	1	2	3	4
Restlessness	0	1	2	3	4
Insomnia	0	1	2	3	4
Startled Awake at Night	0	1	2	3	4

TOTAL ________

SECTION I - SYMPTOMS

Eyes

Watery or Itchy Eyes	0	1	2	3	4
Swollen, Reddened, or Sticky Eyelids	0	1	2	3	4
Dark Circles Under Eyes	0	1	2	3	4
Blurred or Tunnel Vision	0	1	2	3	4

TOTAL ________

Head

Headaches	0	1	2	3	4
Faintness	0	1	2	3	4
Dizziness	0	1	2	3	4
Pressure	0	1	2	3	4

TOTAL ________

Lungs

Chest Congestion	0	1	2	3	4
Asthma or Bronchitis	0	1	2	3	4
Shortness of Breath	0	1	2	3	4
Difficulty Breathing	0	1	2	3	4

TOTAL ________

Heart

Skipped Heartbeats	0	1	2	3	4
Rapid Heartbeats	0	1	2	3	4
Chest Pain	0	1	2	3	4

TOTAL ________

Mind

Poor Memory	0	1	2	3	4
Confusion	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Poor Coordination	0	1	2	3	4
Difficulty Making Decisions	0	1	2	3	4
Stuttering, Stammering	0	1	2	3	4
Slurred Speech	0	1	2	3	4
Learning Disabilities	0	1	2	3	4

TOTAL ________

Nose

Stuffy Nose	0	1	2	3	4
Sinus Problems	0	1	2	3	4
Hay Fever	0	1	2	3	4
Sneezing Attacks	0	1	2	3	4
Excessive Mucous	0	1	2	3	4

TOTAL ________

NAME ______________________ DATE __________

Skin

Symptom					
Acne	0	1	2	3	4
Hives, Rashes, or Dry Skin	0	1	2	3	4
Hair Loss	0	1	2	3	4
Flushing	0	1	2	3	4
Excessive Sweating	0	1	2	3	4

TOTAL ________

Mouth/Throat

Symptom					
Chronic Coughing	0	1	2	3	4
Gagging or Frequent Need to Clear Throat	0	1	2	3	4
Swollen or Discolored Tongue, Gums, Lips	0	1	2	3	4
Canker Sores	0	1	2	3	4

TOTAL ________

Weight

Symptom					
Binge Eating or Drinking	0	1	2	3	4
Craving Certain Foods	0	1	2	3	4
Excessive Weight	0	1	2	3	4
Compulsive Eating	0	1	2	3	4
Water Retention	0	1	2	3	4
Underweight	0	1	2	3	4

TOTAL ________

Joints / Muscles

Symptom					
Pain or Aches in Joints	0	1	2	3	4
Rheumatoid Arthritis	0	1	2	3	4
Osteoarthritis	0	1	2	3	4
Stiffness or Limited Movement	0	1	2	3	4
Pain or Aches in Muscles	0	1	2	3	4
Recurrent Back Aches	0	1	2	3	4
Feeling of Weakness or Tiredness	0	1	2	3	4

TOTAL ________

Other

Symptom					
Frequent Illness	0	1	2	3	4
Frequent or Urgent Urination	0	1	2	3	4
Leaky Bladder	0	1	2	3	4
Genital Itch, Discharge	0	1	2	3	4

TOTAL ________

TOTAL: SECTION I

SECTION II - RISK OF EXPOSURE

Rate each of the following based upon your environmental profile for the past 120 days.

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

Circle the corresponding number to describe the frequency of exposure.

How often are strong chemicals used in your home (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.)?	0	1	2	3	4
How often are pesticides used in your home?	0	1	2	3	4
How often do you have your home treated for insects?	0	1	2	3	4
How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office?	0	1	2	3	4
How often are you exposed to nail polish, perfume, hairspray, or other cosmetics?	0	1	2	3	4
How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?	0	1	2	3	4
How often do you consume non-organic food?	0	1	2	3	4

TOTAL __________

0	**1**	**2**	**3**
No	Mild	Moderate	Drastic

Circle the corresponding number to describe the level of change.

Have you noticed any negative change in your health since you moved into your home or apartment?	0	1	2	3
Have you noticed any change in your health since you started your new job?	0	1	2	3

TOTAL __________

Answer yes or no and circle the corresponding number.	NO	YES
Do you have a water-purification system in your home?	2	0
Do you have an air-purification system in your home?	2	0
Do you have any indoor pets?	0	2
Are you a dentist, painter, farm worker, or construction worker?	0	2

TOTAL __________

TOTAL: SECTION II

SECTION I + SECTION II

To calculate your grand total, combine your totals from section I and section II. If any individual section total equals six or more, or the grand total is 40 or more, you may benefit from a metabolic-detoxification program.

GRAND TOTAL