

Toxic Metals Questionnaire

Detox Support Protocol



NAME

DATE

Mercury Toxicity

Do you have amalgam (silver) fillings in your teeth?

Never
Occasionally
Often
Regularly

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 (arthritis pain, especially in big toes)?	0	1	2	3

Lead Toxicity Total

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