

## Cleansing Quiz

Are you a candidate for a detoxification program at Inner Fire?

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

### SECTION 1: SYMPTOMS

Rate each of the following based upon your health profile for the past 90 days.

#### 1. Digestive

a. Nausea and/or vomiting	0	1	2	3	4
b. Diarrhea	0	1	2	3	4
c. Constipation	0	1	2	3	4
d. Bloating feeling	0	1	2	3	4
e. Belching and/or passing gas	0	1	2	3	4
f. Heartburn	0	1	2	3	4

Total: \_\_\_\_\_

#### 2. Ears

a. Itchy ears	0	1	2	3	4
b. Earaches, ear infections	0	1	2	3	4
c. Drainage from ear	0	1	2	3	4
d. Ringing in ears, hearing loss	0	1	2	3	4

Total: \_\_\_\_\_

#### 3. Emotions

a. Mood swings	0	1	2	3	4
b. Anxiety, fear, nervousness	0	1	2	3	4
c. Anger, irritability	0	1	2	3	4
d. Depression	0	1	2	3	4
e. Sense of despair	0	1	2	3	4
f. Apathy/lethargy	0	1	2	3	4

Total: \_\_\_\_\_

#### 4. Energy / Activity

a. Fatigue/sluggishness	0	1	2	3	4
b. Hyperactivity	0	1	2	3	4
c. Restlessness	0	1	2	3	4
d. Insomnia	0	1	2	3	4
e. Startled awake at night	0	1	2	3	4

Total: \_\_\_\_\_

#### 5. Eyes

a. Watery, itchy eyes	0	1	2	3	4
b. Swollen, reddened or sticky eyelids	0	1	2	3	4
c. Dark circles under eyes	0	1	2	3	4
d. Blurred/tunnel vision	0	1	2	3	4

Total: \_\_\_\_\_

#### 6. Head

a. Headaches	0	1	2	3	4
b. Faintness	0	1	2	3	4
c. Dizziness	0	1	2	3	4
d. Pressure	0	1	2	3	4

Total: \_\_\_\_\_

#### 7. Lungs

a. Chest congestion	0	1	2	3	4
b. Asthma, bronchitis	0	1	2	3	4
c. Shortness of breath	0	1	2	3	4
d. Difficulty breathing	0	1	2	3	4

Total: \_\_\_\_\_

#### 8. Mind

a. Poor memory	0	1	2	3	4
b. Confusion	0	1	2	3	4
c. Poor concentration	0	1	2	3	4
d. Poor coordination	0	1	2	3	4
e. Difficulty making decisions	0	1	2	3	4
f. Stuttering, stammering	0	1	2	3	4
g. Slurred speech	0	1	2	3	4
h. Learning disabilities	0	1	2	3	4

Total: \_\_\_\_\_

#### 9. Mouth / Throat

a. Chronic coughing	0	1	2	3	4
b. Gagging, frequent need to clear throat	0	1	2	3	4
c. Swollen or discolored tongue, gums, lips	0	1	2	3	4
d. Canker sores	0	1	2	3	4

Total: \_\_\_\_\_

#### 10. Nose

a. Stuffy nose	0	1	2	3	4
b. Sinus problems	0	1	2	3	4
c. Hay fever	0	1	2	3	4
d. Sneezing attacks	0	1	2	3	4
e. Excessive mucous	0	1	2	3	4

Total: \_\_\_\_\_

#### 11. Skin

a. Acne	0	1	2	3	4
b. Hives, rashes, dry skin	0	1	2	3	4
c. Hair loss	0	1	2	3	4
d. Flushing	0	1	2	3	4
e. Excessive sweating	0	1	2	3	4

Total: \_\_\_\_\_

#### 12. Heart

a. Skipped heartbeats	0	1	2	3	4
b. Rapid heartbeats	0	1	2	3	4
c. Chest pain	0	1	2	3	4

Total: \_\_\_\_\_

#### 13. Joints / Muscles

a. Pain or aches in joints	0	1	2	3	4
b. Rheumatoid arthritis	0	1	2	3	4
c. Osteoarthritis	0	1	2	3	4
d. Stiffness, limited movement	0	1	2	3	4
e. Pain, aches in muscles	0	1	2	3	4
f. Recurrent back aches	0	1	2	3	4
g. Feeling of weakness or tiredness	0	1	2	3	4

Total: \_\_\_\_\_

#### 14. Weight

a. Binge eating/drinking	0	1	2	3	4
b. Craving certain foods	0	1	2	3	4
c. Excessive weight	0	1	2	3	4
d. Compulsive eating	0	1	2	3	4
e. Water retention	0	1	2	3	4
f. Underweight	0	1	2	3	4

Total: \_\_\_\_\_

#### 15. Other

a. Frequent illness	0	1	2	3	4
b. Frequent or urgent urination	0	1	2	3	4
c. Leaky bladder	0	1	2	3	4
d. Genital itch, discharge	0	1	2	3	4

Total: \_\_\_\_\_

SECTION 1 Total

continued

**SECTION 2: RISK OF EXPOSURE**

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

16. Circle the corresponding number for questions 16a - 16f below.

0	1	2	3	4	
Never	Rarely	Monthly	Weekly	Daily	
a.	How often are strong chemicals used in your home?				0 1 2 3 4
b.	How often are pesticides used in your home?				0 1 2 3 4
c.	How often do you have your home treated for insects?				0 1 2 3 4
d.	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
e.	How often are you exposed to nail polish, perfume, hair spray, and other cosmetics?				0 1 2 3 4
f.	How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?				0 1 2 3 4
<b>Total:</b>					_____

17. Circle the corresponding number for questions 17a - 17b below.

0	1	2	3	
No	Mild Change	Moderate Change	Drastic Change	
a.	Have you noticed any negative change in your health since you moved into your home or apartment?			0 1 2 3
b.	Have you noticed any negative change in your health since you started your new job?			0 1 2 3
<b>Total:</b>				_____

18. Answer yes or no and circle the corresponding number for questions 18a - 18d below.

	NO	YES	
a.	Do you have a water purification system in your home?		2 0
b.	Do you have any indoor pets?		0 2
c.	Do you have an air purification system in your home?		2 0
d.	Are you a dentist, painter, farm worker, or construction worker?		0 2
<b>Total:</b>			_____

**SECTION 2 Total**

**GRAND TOTAL (SECTION 1 + SECTION 2)**

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the Grand Total.  
If any individual section total is 6 or more, or the Grand Total is 40 or more, you may benefit from a Clinical Purification™ program.

**Inner Fire Integrative Health Services**

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