# What Is Your Chemical and Environmental Exposure?

## Lifestyle Evaluation: Chemical and Environmental Exposure Questionnaire

Fill out this questionnaire to see how you score.

Rate each of the following from 0 to 3. If it does not apply, put a 0.
few times a month = 1  weekly = 2  daily or almost daily = 3

### A. Home/Work Environment

_____ 1. How often do you eat out in a restaurant?
_____ 2. How often do you eat fast food?
_____ 3. How often do you cook with vegetable oils?
_____ 4. How often do you prepare/eat boxed meals?
_____ 5. How often do you eat frozen meals?
_____ 6. How often do you use margarine or other types of processed spreads?
_____ 7. How often do you use artificial sweeteners?
_____ 8. How often do you drink flavored drinks with food colorings?
_____ 9. How often do you drink carbonated drinks?
_____ 10. How often do you drink diet drinks?
_____ 11. How often do you eat candy with food colorings?
_____ 12. How often do you eat canned soups?
_____ 13. How often do you eat microwaved popcorn?
_____ 14. How often do you use plastic containers to store your food?
_____ 15. How often do you use perfume or cologne?
_____ 16. How often do you use antibacterial soaps?
_____ 17. How often do you take any prescription medications?
_____ 18. How often do you wear cosmetics?
_____ 19. How often do you color, perm, or straighten your hair?
_____ 20. How often do you burn candles in your home or office?
_____ 21. How often do you use air fresheners?
_____ 22. How often do you use wood cleaners or polishes?
_____ 23. How often do you use mothballs in your home?
_____ 24. How often do you use ammonia for cleaning?
_____ 25. How often do you use bleach (chlorine) in your laundry or for cleaning?
_____ 26. How often do you use scented laundry detergent, softeners, or dryer sheets?
_____ 27. How often do you use powdered, liquid, or foam scrubbing solutions or cleansers in your household?
_____ 28. How often do you use wood to heat your home?
_____ 29. How often are you exposed to smog?
_____ 30. How often do you park your vehicle in a garage attached to the home you live in?
_____ **Section A Total**

### B. What has your exposure been to any of the following?

Rate each of the following from 0 to 3.
If it does not apply, put a 0.

few times a month = 1
weekly = 2
daily or almost daily = 3

_____ 1. Fertilizers
_____ 2. Pesticides
_____ 3. Rodenticides
_____ 4. Herbicides
_____ 5. Fungicides
_____ 6. Paints and paint thinners
_____ 7. Wood preservatives or stains
_____ 8. Alloys (e.g., jewelry making)
_____ 9. Dyes (e.g., textiles)
_____ 10. Other:
_____ **Section B Total**

### C. Have you ever worked in any of the following areas?

(yes = 3, no = 0)

_____ 1. Chemical processing
_____ 2. Electroplating
_____ 3. Soldering
_____ 4. Welding
_____ 5. Metal cutting
_____ 6. Leather tanning
_____ 7. Fireworks
_____ 8. Metal smelting
_____ 9. Photographic darkroom
_____ 10. Hair salon
_____ 11. Nail salon
_____ 12. Other:
_____ **Section C Total**

### D. General Miscellaneous Exposures

_____ 1. Have you ever worked in a mine? (yes = 3, no = 0)
_____ 2. Have you ever had silver amalgam fillings in your teeth? (yes = 3, no = 0)
_____ 3. Do you have any tattoos with colored ink? (yes = 3, no = 0)
If yes, please circle which:
red yellow green white blue black
_____ 4. Do you receive flu shots or other vaccinations? (yes = 3, no = 0)
_____ 5. Do you have any other type of metal in your mouth? (yes = 3, no = 0)
_____ 6. Do you currently smoke cigarettes? (yes = 3, no = 0)
_____ If not, have you smoked cigarettes in the past? (yes = 2, no = 0)
_____ 7. Do you currently use any other type of tobacco products? (yes = 3, no = 0)
_____ If not, have you used any other type of tobacco product in the past? (yes = 2, no = 0)
_____ 8. Are you exposed to secondhand smoke? (yes = 3, no = 0)
_____ 9. Does your home, work, school, or car have a damp or mildew smell? (yes = 3, no = 0)
_____ 10. Have you ever had water damage in your home, work, or school? (yes = 3, no = 0)
_____ 11. Does spending time in your basement cause or worsen your symptoms? (yes = 3, no = 0)
_____ 12. Does spending time in a different location change your symptoms? If so, are they better or worse? (yes = 3, no = 0)
_____ 13. Do you develop symptoms when you smell perfume, cologne, or strong odors? (yes = 3, no = 0)
_____ **Section D Total**

### E. Water

1. Where does your primary water source come from? (please circle)
municipal well home filtering system
bottled other:

2. What is your approximate daily water intake in ounces? (1 cup water = 8 ounces)

_____ **Total A**
_____ **Total B**
_____ **Total C**
_____ **Total D**
_____ **Grand total**

### Score Between 0 and 15

Good job. Recommendations: 21-day Standard Process Purification Program once a year and continued vigilance to avoid chemical exposure

### Score Between 16 and 30

Room for improvement. Recommendations: 21-day Standard Process Purification Program once a year, possible lifestyle changes, and increasing awareness to avoid chemical exposure

### Score Above 30

Need to rethink habits. Recommendations: 21-day Standard Process Purification Program twice a year, possible lifestyle changes, and a serious plan to avoid chemical exposure

**Contact our office to learn more about the 21-Day Purification Program and how to improve your health.**


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