



Bio-Toxicity Self Assessment Test

How Toxic Are You?

Yes - No Mark the symptoms you experience:

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you feel tired or fatigued? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you experience early morning stiffness? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you feel stiff after periods of rest? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you feel dizzy, foggy-headed or have trouble concentrating? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you experience cracking joints? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you experience frequent back pain or headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you eat fast, fatty, processed or fried foods? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you experience generalized aches and pains in the body? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use coffee, cigarettes, candy or soda to get "up". |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you sleepy in the afternoon? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you experience intestinal gas and bloating after meals? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you bruise easily? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you recover slowly from moderate exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you feel you don't exercise enough or feel sluggish and need to lose weight? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have food allergies, or are often exposed to chemicals, sedatives or stimulants? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take pain relievers to get rid of aches and pains? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a family history of arthritis or auto-immune disorders? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your bowels move less than twice per day? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does "airing out" (opening windows) in your office/bedroom a few minutes each day make you feel better? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use regular municipal water (non-filtered) for your shower? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you purchase food in the conventional section of the grocery store, instead of buying organic fresh foods? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you change/replace the filter for the heating/air conditioning twice a year? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you thought about trying a cleansing program recently to rid your body of toxins? |

If your YES score totals 4 or greater, your current symptoms might be due to toxic overload and may suggest you need a detoxification program to purify your system of toxins to experience **PAIN-FREE** living.

For more information on body detoxification & our 3-Week Detox Program, please contact the InnerMovement Chiropractic & Wellness Office at (818) 549-1300 or visit our website at <http://www.innermovement.net/> to schedule an appointment.