Name: Date:

Toxicity Symptom Check List

Environmental or microbial toxins affect our body and produce different symptoms depending on the toxicity to a specific organ. The following symptom group checklist is designed to help the practitioner assess a patient's potential needs for the Wei Detox Program™.

Check the number by using:

1 = Occasional, Not Severe

2 = Occasional, Severe

3 = Frequent, Not Severe

4 = Frequent, Severe

1) Digestive:	
a. Nausea and/or vomiting	1 2 3 4
b. Diarrhea	1 2 3 4
c. Constipation	1 2 3 4
d. Bloated feeling	1 2 3 4
e. Belching and/or passing gas	1 2 3 4
f. Heartburn	1 2 3 4
g. Food sensitivities	1 2 3 4
h. Craving certain foods	1 2 3 4
i. Compulsive eating	1 2 3 4
j. Learning disability	1 2 3 4
k. Poor concentration	1 2 3 4
Total	

2) Lung:	
a. Chronic cough	1 2 3 4
b. Chest congestion	1 2 3 4
c. Bronchitis	1 2 3 4
d. Excessive phlegm or mucus	1 2 3 4
e. Shortness of breath	1 2 3 4
f. Frequent cold or illness	1 2 3 4
g. Frequent need to clear throat	1 2 3 4
Total	

3) Liver:	
a. Mood swings	1 2 3 4
b. Anxiety, fear, or nervousness	1 2 3 4
c. Anger/irritability	1 2 3 4
d. Insomnia	1 2 3 4
e. Blurred/tunnel vision	1 2 3 4
f. Headaches	1 2 3 4
g. Vision Weakness	1 2 3 4
h. Reduced stress tolerance	1 2 3 4
Total	

4) Heart:	
a. Skipped heartbeat	1 2 3 4
b. Rapid heartbeat	1 2 3 4
c. Difficulty breathing	1 2 3 4
d. Chest pain	1 2 3 4
Total	

5) Lymphatic:	
a. Fatigue	1 2 3 4
b. Sluggishness	1 2 3 4
c. Body or leg heaviness	1 2 3 4
d. Ringing in the ear	1 2 3 4
e. Dizziness/faintness	1 2 3 4
Total	

6) Blood Circulation:	
a. Hay fever	1 2 3 4
b. Hives, rashes, or dry skin	1 2 3 4
c. Watery or itchy eyes	1 2 3 4
d. Asthma	1 2 3 4
e. Swollen, reddened, or sticky eyelids	1 2 3 4
f. Swollen or discolored tongue	1 2 3 4
g. Canker sores	1 2 3 4
h. Sneezing attack	1 2 3 4
i. Allergies	1 2 3 4
j. Poor circulation	1 2 3 4
k. Itchy ear	1 2 3 4
l. Ear aches	1 2 3 4
m. Stuffy nose	1 2 3 4
n. Bleed easily	1 2 3 4
o. Swollen gums,lips	1 2 3 4
Total	

8) Kidney:	
a. Hearing loss	1 2 3 4
b. Hyperactivity	1 2 3 4
c. Restlessness	1 2 3 4
d. Awake at night	1 2 3 4
e. Dark circles under eyes	1 2 3 4
f. Hair loss	1 2 3 4
g. Flushing	1 2 3 4
h. Excessive sweating	1 2 3 4
i. Pain/ache in joints	1 2 3 4
j. Stiffness or limited movement	1 2 3 4
k. Recurrent back aches	1 2 3 4
l. Pain/aches in muscles	1 2 3 4
m. Feeling of weakness or tiredness	1 2 3 4
n. Water retention	1 2 3 4
o. Decreased libido	1 2 3 4
Total	

7) Women's Health:	
a. Genital Itch/discharge	1 2 3 4
b. Menstrual cramping	1 2 3 4
c. Leaky bladder	1 2 3 4
d. Frequent/urgent urination	1 2 3 4
Total	

9) Men's Health:	
a. Leaky bladder	1 2 3 4
b. Difficulty urinating	1 2 3 4
c. Frequent/urgent urination	1 2 3 4
Total	

Cummulative total:_____

Current diagnosed medical conditions:_____

Previous diagnosed medical conditions:_____

Please fill out this form before and after each step of the detox (every 7 days)