

# HOW TOXIC ARE YOU?

*Is your body a toxic waste dump?*

*These may be early warning signs that guide us to cleanse our bodies of impurities.*

*Take this test.*

	Yes	No
1. Do you often feel tired or fatigued?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you feel dizzy, foggy-headed or have trouble concentrating?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you use coffee, cigarettes, candy or soda to get "up"?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you eat fast, fatty, processed or fried foods?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do your bowels move less than twice a day?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you experience intestinal gas and bloating or constipation?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you experience headaches or yeast difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you live with or near air and water pollution?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you experience general aches and pains or arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have food allergies or skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you experience frequent back pains or sinus problems?	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you often exposed to chemicals, sedatives, or stimulants?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you rarely exercise or feel sluggish or overweight?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you done a cleansing program before?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered **"yes"** to three or more of these questions, or **"no"** to the last question, it would be desirable for you to rid your system of toxins.

Name \_\_\_\_\_ Age \_\_\_\_\_ Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

E-mail Address \_\_\_\_\_ Cellular Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/Postal \_\_\_\_\_