CHILD TOXIN EXPOSURE QUESTIONNAIRE

If you have been exposed to any of these in the LAST 12 MONTHS please check:

- **(Y)** Yes
- **(N)** No
- **(?)** Unknown
- **(P)** for exposure before 12 months ago

Community

Do you have regular exposure to:	Y	N	?	P	Notes
Automobile exhaust					
Farm/Industrial/Power plant or lines					
Radio tower					
Landfill/Dump					
Hydro tower					

Home and/or Work Environment

Do you live in a: (Circle one)	House	Apartment Building	Mobile Home
Do you work in a: (Circle one)	House	Office Building	Factory
Bathing/Showering water source: (Circle one)	Well	Public Works	Bottled

Do you have regular exposure at home or work to:	Y	N	?	P	Notes
Forced air heat					
Renovations (new carpets; add ons; etc…)					
Basement cracks or dirt floor					
Damp basement or crawl space					
Wet windows or outside closet walls					
Water leaks (ceilings, walls, floors)					
Visible mold					
Old or cracking ceiling tiles					
Old or cracking vinyl linoleum flooring					
Crumbling pipe insulation					
Crumbling wall or ceiling insulation					

Old or cracking paint					
Carpets or rugs					
Stagnant or stuffy air					
Gas or propane stove					
Coal or wood stove					
Other gas appliance (water heater, furnace)					
Regular contact with smokers					

Do you have regular exposure to:	Y	N	?	P	Notes
Pesticides or herbicides					
Harsh chemicals (varnish, glue, gas, acid…)					
Welding or soldering					
Metals (Lead, Mercury, etc)					
Paints					
Photo developing / Dark room					
Airplane travel					
Cleaning chemicals					

Hobby and Work Activities

Drinking/Cooking water source: Well Public Works Bottled Filtered

Caffeine? What kind: How Much:

Do you regularly eat:	Y	N	?	P	Notes
Fish (fresh, frozen, canned, etc.)					
Artificial sweeteners (Circle one): NutraSweet, Equal, Aspartame, Splenda					
Alcohol					
Animal products					
• How often?					
• What percentage of your animal product is organic?					
Do you wash your produce					
• What percentage of your produce is organic?					
Deep fat fried foods					

Sodas, juices, drinks containing High Fructose Corn Syrup – how many per day?				
Do you have:	**Y**	**N**	**?**	**P**
Allergies				
Sensitivity to smells (gas, perfume, paint, etc…)				
Artificial materials in the body (implants, pins, joints, etc…)				
Immunizations				
Have you ever:	**Y**	**N**	**?**	
Used tobacco				
Experimented with recreational drugs				
Led a high stress lifestyle				
Experienced a stressful or traumatic event				
Been under anesthesia				
Had an illness during foreign travel				
Had an illness while camping or hiking				
Had food poisoning				

Personal - Diet

Dental

	Y	N	?	Notes
Do you currently have amalgam fillings or caps?				
• How many amalgam fillings do you have now?				
Have you removed or lost dental fillings or caps?				
Did you have fillings as a child?				
• How many fillings did you have?				
Did you have your Wisdom teeth removed?				
• At what age?				
• Any complications such as dry socket or abscesses?				

Do you have any root canal treated teeth?				
• How many and when were they placed?				
Did your mother have dental fillings prior to giving birth to you?				
• During her pregnancy with you?				
Other:				

Age of school building:					
Location of school building: Rural City Suburban					
Do you have regular exposure at school to:	**Y**	**N**	**?**	**P**	**Notes**
Automobile exhaust					
Farm/Industrial/Power plant or lines					
Radio tower					
Landfill/Dump					
Water tower					
Renovations (carpeting, ceiling tiles, rooms)					
Outdoor activities (recess, sports, etc.)					
Other:					

School

Please list all **PRESCRIPTION** or **OVER THE COUNTER** medications you currently take on a regular basis, including birth control pills and allergy injections:

Name of medication	Dose (mg, ML, IU)	How often do you take it?	How long have you taken it?	If you have side effects, please specify

Please list all **VITAMINS/MINERALS**, **HERBS**, or **OTHER SUPPLEMENTS** you currently take on a regular basis:

Name of supplement	Dose (mg, ML, IU)	How often do you take it?	How long have you taken it?	If you have side effects, please specify

Drug Adverse Reactions: Please list ANY medication / anesthetics / immunizations you have had to stop taking because of side effects or allergic reactions:

Name of medication/ immunization	Type of side effects or allergic reaction that caused you to stop it	Age	Year