Back In Action Chiropractic

20416 Bowfonds St, Ashburn, VA 20147
Office: 703-858-3575 / Fax: 703-858-3876 / Cell: 703-673-6333
http://www.back-n-action.com/

Toxic Exposure Questionnaire

NAME____ DATE________________________

Please answer the following questions. Use the back of the page to elaborate if needed.

____ Do you experience symptoms more often in any particular location?

    ____ Home ____ Work ____ Specific Room ____ Specific Area

____ Do you experience symptoms more at certain times of the year?

____ Is your home ventilated?

    ____ Workplace?

____ Do you live or work in a structure that has been flooded in the past?

____ Can you smell or see mold in any of the areas where you live or work?

____ Has any remodeling been done at home or work in the last year?

____ Have you lived or worked in freshly painted rooms in the last six months?

Is your house ____ partly carpeted ____ Mostly carpeted ____ Fully carpeted?

____ Have you been exposed to new carpets or furniture in the past year?

____ Do you use plastic containers or plastic wrap when you microwave food?

____ Has your home or workplace been treated chemically for pest in the last year?

____ Have you been exposed to other chemicals or fumes at home or work in the last year?

When did you last check/clean/replace the filters for your furnace and air conditioner?

How often do you check/clean/replace these filters? ____________

____ Do you run a humidifier during the dry months?

    How often do you check/clean/replace the humidifier filter? ____________

When was your house last checked for carbon monoxide? ____________

    Workplace? ____________

____ Do you use typical household cleaners?

    ____ Or organic, non-toxic cleaning products?

____ Do you use household air fresheners or plug-ins?

____ Do you use scented laundry detergent? ____ Scented fabric softeners?

____ Do you spray your shower walls with shower cleaners after showering?

____ Are you regularly exposed to cigarette smoking? ____ Do you smoke?

    How often? ____________

____ Are you exposed to wood-finishing chemicals? ____ Glues? ____ Solvents? ____ Adhesives?

    ____ Gasoline? ____ Other? (If so, please list: ____)

____ Is your lawn treated chemically?

    How often? ____________

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____ Do you use pesticides, herbicides, or other chemicals?

(If so, please list: ____)

____ Do you have mercury amalgam fillings (silver fillings)?

How many? ____________

____ Do you have any root canals?

How many? ____________ How old are they? ____________

____ Have you worked in a dental office?

What type? ____________

____ Have you had any mercury amalgam fillings removed?

How many? ____________ When? ____________ What precautions were used? _____________________

Do you do any of the following types of work?

____ Auto body work	____ Building construction	____ Hairdressing
____ Welding	____ Printing shop	____ Carpet laying
____ Nail salon	____ Automotive mechanic	____ Painting
____ Dry cleaning	____ Landscaping	____ Commercial farming

Do you live ____ in the city ____ in farming country ____ near busy streets ____ near a golf course

____ near a source of air/water pollution?

____ Do you live near a source of any type of pollution?

What type(s)? ____

____ Do live or work near any high-powered electrical wires or transformers?

____ Any other types of exposure to chemicals?

What type(s)? ____

____ Do you drink any tap water?

How often do you eat “fast foods”? ____________

____ Have you had the usual childhood vaccinations?

Any additional vaccinations (military, overseas travel)? ____

Anything else that you can think of that is or may have been a toxic exposure?

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