

The Purification Program – Teleseminar Handout

When you eat _____ you ingest _____

_____ and can cause you to feel _____.

When you eat foods that were _____, you're ingesting a lot of

_____ Eating animal products from animals _____

_____ adds more _____ your body has to deal with.

In addition to the food you eat, toxins can enter your body from the

- _____
- _____
- _____

A healthy body _____

And a body that is storing all kinds of toxic chemicals _____

With over _____ of the adults in the U.S. being overweight, _____

Your _____ serves a purpose to protect your _____

A great deal of the toxins stored in your body are stored in your _____

In most cases, obesity is a symptom of _____

So, your body must be _____ – before you can _____

Once you _____, you will find that your body will _____.
_____ . How much weight you lose depends, _____.

Take a look at the chart “**Traditional Diet vs. Cleansing**” in your handout.

On a traditional diet, when you lose weight, but do not detoxify, the excess fat is gone but _____

When you cleanse and detoxify, _____

Weight Loss Principles

- _____
- _____
- _____
- _____
- _____

Everyone needs to _____
in order to be _____

Complete the

- Toxicity Questionnaire
- Symptom Survey Form

Click the link at the bottom of

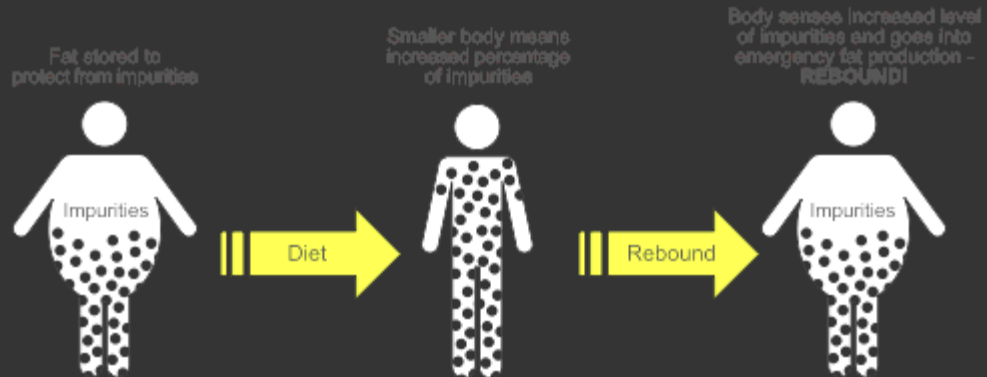
<http://www.healthyeatingadvisor.com/thepurificationprogram.html> to contact

Dr. Farlow for your FREE Consultation

Traditional Diet vs. Cleansing

One of the ways the liver deals with impurities is to increase body fat to enfold these impurities and to protect the body from their influence. Diets are not successful for long term weight loss because they don't address the need to cleanse the body of impurities.

Traditional Diet



Cleansing



Shed Pounds without the Rebound!

Name: _____

Date: _____

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a purification program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloating feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4
Total:	_____

2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4
Total:	_____

3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4
Total:	_____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4
Total:	_____

5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4
Total:	_____

6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4
Total:	_____

7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4
Total:	_____

8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4
Total:	_____

9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4
Total:	_____

10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4
Total:	_____

11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4
Total:	_____

12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4
Total:	_____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Rheumatoid arthritis	0 1 2 3 4
c. Osteoarthritis	0 1 2 3 4
d. Stiffness or limited movement	0 1 2 3 4
e. Pain or aches in muscles	0 1 2 3 4
f. Recurrent back aches	0 1 2 3 4
g. Feeling of weakness or tiredness	0 1 2 3 4
Total:	_____

14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4
Total:	_____

15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4
Total:	_____

Section I Total: _____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a-16f below.									
0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

- | | |
|--|-----------|
| a. How often are strong chemicals used in your home?
(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) | 0 1 2 3 4 |
| b. How often are pesticides used in your home? | 0 1 2 3 4 |
| c. How often do you have your home treated for insects? | 0 1 2 3 4 |
| d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office? | 0 1 2 3 4 |
| e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics? | 0 1 2 3 4 |
| f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? | 0 1 2 3 4 |

Total: _____

17. Circle the corresponding number for questions 17a-17b below.							
0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

- | | |
|---|---------|
| a. Have you noticed any negative change in your health since you moved into your home or apartment? | 0 1 2 3 |
| b. Have you noticed any change in your health since you started your new job? | 0 1 2 3 |

Total: _____

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

- | | No | Yes |
|---|----|-----|
| a. Do you have a water purification system in your home? | 2 | 0 |
| b. Do you have any indoor pets? | 0 | 2 |
| c. Do you have an air purification system in your home? | 2 | 0 |
| d. Are you a dentist, painter, farm worker, or construction worker? | 0 | 2 |

Total: _____

Section II Total:	_____
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Grand Total (Section I & Section II)	_____
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Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a purification program.

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.

SYMPTOM SURVEY FORM

NAME _____ DOCTOR _____ DATE _____

Phone # () _____

Birthdate: ___/___/___ Sex: M ___ F ___

INSTRUCTIONS: Number the boxes which apply to you with either a 1, 2, or 3
 (1) for MILD symptoms
 (2) for MODERATE symptoms
 (3) for SEVERE symptoms
 Leave the box BLANK if it does not apply to you!

GROUP 1

- 1 Acid foods upset
- 2 Get chilled, often
- 3 "Lump" in throat
- 4 Dry mouth-eyes-nose
- 5 Pulse speeds after meals
- 6 Keyed up—fail to calm
- 7 Cuts heal slowly
- 8 Gag easily
- 9 Unable to relax; startles easily
- 10 Extremities cold, clammy
- 11 Strong light irritates
- 12 Urine amount reduced
- 13 Heart pounds after retiring
- 14 "Nervous" stomach
- 15 Appetite reduced
- 16 Cold sweats often
- 17 Fever easily raised
- 18 Neuralgia-like pains
- 19 Staring, blinks little
- 20 Sour stomach frequent

GROUP 2

- 21 Joint stiffness after arising
- 22 Muscle-leg-toe cramps at night
- 23 "Butterfly" stomach, cramps
- 24 Eyes or nose watery
- 25 Eyes blink often
- 26 Eyelids swollen, puffy
- 27 Indigestion soon after meals
- 28 Always seems hungry; feels "lightheaded" often
- 29 Digestion rapid
- 30 Vomiting frequent
- 31 Hoarseness frequent
- 32 Breathing irregular
- 33 Pulse slow; feels "irregular"
- 34 Gagging reflex slow
- 35 Difficulty swallowing
- 36 Constipation, diarrhea alternating
- 37 "Slow starter"
- 38 Get "chilled" infrequently
- 39 Perspire easily
- 40 Circulation poor, sensitive to cold
- 41 Subject to colds, asthma, bronchitis

GROUP 3

- 42 Eat when nervous
- 43 Excessive appetite
- 44 Hungry between meals
- 45 Irritable before meals
- 46 Get "shaky" if hungry
- 47 Fatigue, eating relieves
- 48 "Lightheaded" if meals delayed
- 49 Heart palpitates if meals missed or delayed
- 50 Afternoon headaches
- 51 Overeating sweets upsets
- 52 Awaken after few hours sleep—hard to get back to sleep
- 53 Crave candy or coffee in afternoons
- 54 Moods of depression—"blues" or melancholy
- 55 Abnormal craving for sweets or snacks

GROUP 4

- 56 Hands and feet go to sleep easily, numbness
- 57 Sigh frequently, "air hunger"
- 58 Aware of "breathing heavily"
- 59 High altitude discomfort
- 60 Opens windows in closed room
- 61 Susceptible to colds and fevers
- 62 Afternoon "yawner"
- 63 Get "drowsy" often
- 64 Swollen ankles worse at night
- 65 Muscle cramps, worse during exercise; get "charley horses"
- 66 Shortness of breath on exertion
- 67 Dull pain in chest or radiating into left arm, worse on exertion
- 68 Bruise easily, "black/blue" spots
- 69 Tendency to anemia
- 70 "Nose bleeds" frequent
- 71 Noises in head or "ringing in ears"
- 72 Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

- 73 Dizziness
- 74 Dry skin
- 75 Burning feet
- 76 Blurred vision
- 77 Itching skin and feet
- 78 Excessive falling hair
- 79 Frequent skin rashes
- 80 Bitter, metallic taste in mouth in mornings
- 81 Bowel movements painful or difficult
- 82 Worrier, feels insecure
- 83 Feeling queasy; headache over eyes
- 84 Greasy foods upset
- 85 Stools light-colored
- 86 Skin peels on foot soles
- 87 Pain between shoulder blades
- 88 Use laxatives
- 89 Stools alternate from soft to watery
- 90 History of gallbladder attacks or gallstones
- 91 Sneezing attacks
- 92 Dreaming, nightmare type bad dreams
- 93 Bad breath (halitosis)
- 94 Milk products cause distress
- 95 Sensitive to hot weather
- 96 Burning or itching anus
- 97 Crave sweets

GROUP 6

- 98 Loss of taste for meat
- 99 Lower bowel gas several hours after eating
- 100 Burning stomach sensations, eating relieves
- 101 Coated tongue
- 102 Pass large amounts of foul-smelling gas
- 103 Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 104 Mucus colitis or "irritable bowel"
- 105 Gas shortly after eating
- 106 Stomach "bloating" after eating

GROUP 7

(A)

- 107 Insomnia
- 108 Nervousness
- 109 Can't gain weight
- 110 Intolerance to heat
- 111 Highly emotional
- 112 Flush easily
- 113 Night sweats
- 114 Thin, moist skin
- 115 Inward trembling
- 116 Heart palpitates
- 117 Increased appetite without weight gain
- 118 Pulse fast at rest
- 119 Eyelids and face twitch
- 120 Irritable and restless
- 121 Can't work under pressure

(B)

- 122 Increase in weight
- 123 Decrease in appetite
- 124 Fatigue easily
- 125 Ringing in ears
- 126 Sleepy during day
- 127 Sensitive to cold
- 128 Dry or scaly skin
- 129 Constipation
- 130 Mental sluggishness
- 131 Hair coarse, falls out
- 132 Headaches upon arising wear off during day
- 133 Slow pulse, below 65
- 134 Frequency of urination
- 135 Impaired hearing
- 136 Reduced initiative

GROUP 7 (continued)

(C)

- 137 Failing memory
- 138 Low blood pressure
- 139 Increased sex drive
- 140 Headaches, "splitting or rending" type
- 141 Decreased sugar tolerance

(D)

- 142 Abnormal thirst
- 143 Bloating of abdomen
- 144 Weight gain around hips or waist
- 145 Sex drive reduced or lacking
- 146 Tendency to ulcers, colitis
- 147 Increased sugar tolerance
- 148 Women: menstrual disorders
- 149 Young girls: lack of menstrual function

(E)

- 150 Dizziness
- 151 Headaches
- 152 Hot flashes
- 153 Increased blood pressure
- 154 Hair growth on face or body (female)
- 155 Sugar in urine (not diabetes)
- 156 Masculine tendencies (female)

(F)

- 157 Weakness, dizziness
- 158 Chronic fatigue
- 159 Low blood pressure
- 160 Nails weak, ridged
- 161 Tendency to hives
- 162 Arthritic tendencies
- 163 Perspiration increase
- 164 Bowel disorders
- 165 Poor circulation
- 166 Swollen ankles
- 167 Crave salt
- 168 Brown spots or bronzing of skin
- 169 Allergies—tendency to asthma
- 170 Weakness after colds, influenza
- 171 Exhaustion—muscular and nervous
- 172 Respiratory disorders

FEMALE ONLY

- 173 Very easily fatigued
- 174 Premenstrual tension
- 175 Painful menses
- 176 Depressed feelings before menstruation
- 177 Menstruation excessive and prolonged
- 178 Painful breasts
- 179 Menstruate too frequently
- 180 Vaginal discharge
- 181 Hysterectomy/ovaries removed
- 182 Menopausal hot flashes
- 183 Menses scanty or missed
- 184 Acne, worse at menses
- 185 Depression of long standing

MALE ONLY

- 186 Prostate trouble
- 187 Urination difficult or dribbling
- 188 Night urination frequent
- 189 Depression
- 190 Pain on inside of legs or heels
- 191 Feeling of incomplete bowel evacuation
- 192 Lack of energy
- 193 Migrating aches and pains
- 194 Tire too easily
- 195 Avoids activity
- 196 Leg nervousness at night
- 197 Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main health complaints you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____