National Census Plan

Technology Habits and Symptoms Associated with Electromagnetic Sensitivity Concerns

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A National Screening Initiative Using EFEIA Questionnaires A and B
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Executive Proposal

EFEIA Foundation proposes a National Census Plan built exclusively around two existing instruments: Questionnaire A on technology habits and multiple sensitivities, and Questionnaire B on 25 reported symptoms. The aim is to create a practical national baseline linking how people use technology with the symptom patterns they report.

The two-questionnaire model is the proposed national entry point. It can identify reported symptom burden, describe technology-use patterns, and flag profiles for further review without requiring a full clinical evaluation or an environmental measurement visit before participation. Specialized versions would serve teenagers and autistic people, with appropriate accessibility and respondent identification.

EFEIA is bringing an existing protocol and a substantial field history to this initiative. According to the proposing organization, the NOXTAK Project has more than ten years of experience involving more than 10,000 people, including thousands of people reporting electrosensitivity and thousands of encounters involving psychological or contextual contributors to distress. This experience informs the proposal; it is distinct from the smaller documented research cohorts. [1]

The core output would be an EFEIA A–B screening profile: an interpretable relationship between technology lifestyle, multiple sensitivities, total symptom burden, and symptom distribution. It would be a questionnaire-based marker for population screening and research, not a laboratory biomarker or a diagnosis of EMF-induced disease.

The Plan would operate over six months of preparation, twelve months of census data collection, and six months of analysis, with a first report at Month 24. Government support is requested for protocol standardization, accessible participation, national recruitment, independent analysis, and public reporting.

This proposal defines the national census component. The broader EFEIA assessment and care protocol remains available for appropriate follow-up; it is not a prerequisite for completing the census.

1 Purpose and Scope

The immediate purpose is to make a large-scale, standardized assessment feasible: two questionnaires, one linked record, and one consistently defined screening profile. The census would document potential concerns and their distribution rather than require participants to prove a cause before their experiences can be recorded.

- Describe technology habits and multiple sensitivities across participating populations.
- Quantify the frequency and pattern of the 25 symptoms recorded in Questionnaire B.
- Examine associations between A and B while separating their distinct domains.
- Identify profiles that may benefit from information, follow-up, or clinical review.
- Develop comparable but appropriately adapted teenager and autism-accessible versions.
- Provide a baseline for subsequent waves, independent validation, and targeted research.

The census assessment would consist exclusively of A and B. Administrative information needed for consent, age eligibility, geography, recruitment, respondent type, and record linkage would accompany them. It would not introduce an additional health questionnaire.

Questionnaire C, Questionnaires D and E, environmental checklists, instrument measurements, clinical examinations, and intervention programs belong to separate follow-up pathways. A person would not need to complete them, purchase a product, or accept a particular explanation of symptoms to participate.

2 Why the Two Questionnaire Model Is Useful

Questionnaire A provides the lifestyle context. Questionnaire B supplies the symptom profile. Together they are sufficient for the proposed first-level task: recording possible concerns, examining associations, and prioritizing further attention. They are not sufficient by themselves to determine whether an individual's symptoms have a physiological, psychological, electromagnetic, or mixed cause.

Sleep-related symptoms already present in B would remain part of that instrument. A separate sleep survey would not be required. The census would preserve this limited scope and avoid turning a brief national initiative into the complete EFEIA clinical protocol.

The term national census describes a nationwide voluntary enumeration initiative. It does not imply compulsory participation, complete enumeration of the United States population, government endorsement, or statutory census authority.

3 Existing Protocol and NOXTAK Experience

The proposal is an implementation and standardization of an existing EFEIA framework. Its Phase 1 materials describe technology habits, symptom scoring, and contextual interpretation. The scoring workbook provides detailed item rules. The Scientific Circle materials provide a potential structure for project-specific scientific working groups. [2–4]

The proposed national instrument is an A–B subset of the broader protocol. It would retain a controlled lineage to the original instruments while documenting adaptations for census use. It would not reuse the A+B+C composite or its thresholds after removing C.

Evidence layer	Contribution to the national proposal
NOXTAK field history	More than ten years and more than 10,000 people, as reported by the proposing organization. Supports operational experience and hypothesis development; not a single audited clinical cohort. [1]
2014–2018 observational report	Describes 357 people and a 144-person intervention subset using an earlier 29-symptom questionnaire. Provides historical context, not direct validation of the present 25-item B scale. [5]
2025 Global Census	Reports A responses from 283 people and B responses from 141 people, within a reported enrollment of 286. Demonstrates prior application; linked A–B sample size requires record-level confirmation. [6, 7]
Current protocol materials	Define the existing tools and professional framework. Provide a starting point for a fixed national version, training, and independent methods review. [2–4, 8]

The updated 10,000-person organizational account replaces the earlier 1,500-person experience statement for this proposal. These figures must not be added together. Neither the historical reports nor the survey totals would be added to the 10,000 figure without deduplication and a defined accounting period.

Experience involving psychological or contextual contributors would be documented with the same care as reports of electrosensitivity. Psychological processes can produce genuine physical symptoms and can coexist with medical conditions; the census would not impose a psychological-versus-physiological classification from A and B alone.

4 The National A–B Instrument

Instrument	Content and proposed output
Questionnaire A	Technology use, proximity and nighttime routines, screen habits, lifestyle factors, and multiple sensitivities. Retain item responses, official total where verified, and separately identified domains.
Questionnaire B	The existing 25 symptom items with a 0–10 response format. Retain each response, total score, number of elevated items, and a predefined symptom-domain profile.
Linked record	Connect the A and B responses for the same participant, with instrument version, completion status, respondent type, age band, and appropriate geographic information.

The workbook states an A maximum of 106 and a B maximum of 250. The national scoring engine would use these totals only after the item list, answer options, scoring rules, and achievable maximum have been reconciled. Different A forms in the supplied materials do not contain identical content. [3, 4, 8]

B is described in different materials in terms of frequency, intensity, or both. A national version must specify one response construct and a clear recall period. The current workbook anchors frequency from never to almost daily. If that format is retained, B would be reported as symptom-frequency burden rather than silently interpreted as intensity.

A and B would remain separately scored. No new A+B diagnostic total or conversion of the three-survey composite into a two-survey score would be introduced without validation.

5 Preventing Circular Associations

Questionnaire A includes multiple sensitivities and, in the workbook, discomfort during a phone call. Those items overlap conceptually with the symptoms measured by B. A correlation between the entire A score and B therefore cannot be interpreted as an independent relationship between electromagnetic exposure and health.

The analysis would distinguish a technology-habits item set, a sensitivity item set, other lifestyle domains, and symptom-like A items. A prespecified habits analysis would exclude symptom-like items from its predictor set. The full legacy A score would remain available for traceability, while any derived subscore would carry a separate name and version.

Technology habits would be treated as behavioral indicators, not measured electromagnetic dose. Diet, grounding, water preferences, and similar A items would not be assumed to be established biological protection measures merely because they carry legacy score weights.

6 The EFEIA A–B Screening Profile

The proposed marker is a structured profile rather than a claim that one number identifies a cause. It combines the verified A total and domains with the B total and item pattern. Technology-habit and sensitivity domains would remain visible so that one cannot substitute for the other.

Observed pattern	Screening interpretation
Lower habits score and lower B burden	Lower reported technology-habit score with fewer reported symptoms. A descriptive reference pattern, not proof of protection or absence of disease.
Higher habits score and lower B burden	More intensive reported technology habits with fewer symptoms. Useful for comparison; does not prove resilience or exclude future concerns.
Lower habits score and higher B burden	Substantial reported symptoms despite a lower habits score. Supports broader follow-up; does not establish physiological hypersensitivity or nocebo.
Higher habits score and higher B burden	Co-occurrence of more intensive habits and greater symptom burden. Flags a potential association for review; does not establish electromagnetic causation.

Higher and lower would be defined prospectively for each analysis using documented legacy bands or explicitly descriptive study cut points. Continuous-score analysis would be primary. Sample-derived quartiles would be labeled relative positions in that sample, not clinical thresholds.

The legacy B bands of 0–39, 40–58, 59–71, 72–110, and 111–250 may be retained as historical score categories, with their EFEIA origin disclosed. Participant-facing outputs would state the numeric band and reported burden without declaring confirmed EHS, onset, or progression. [3, 4]

A priority flag would indicate an offer of review, not a diagnosis. Severe individual complaints would not be hidden by a low total. Clinician-reviewed response guidance would direct participants reporting urgent symptoms toward appropriate medical services without attempting to determine urgency from an unvalidated EHS score alone.

The screening profile would support selection for later studies of measured exposure, expectations, symptoms, and clinical findings. These later assessments would not be added to the mandatory national A–B census.

7 Teenager and Autism Accessible Versions

The national program would develop a standard adult version, a teenager version, and an autism-accessible version of A and B. These are two-questionnaire pathways, not extra instruments. Initial age definitions would be adults aged 18 and older and teenagers aged 13–17, subject to pediatric and ethics review.

Version	Required adaptation
Adult A and B	Preserve the approved core items and scoring, with clear response anchors, language versions, and accessible modes.
Teenager A and B	Adapt technology examples to school, gaming, social use, and family routines. Review adult-specific nutrition and lifestyle items; do not transfer adult cutoffs automatically.
Autism accessible A and B	Provide plain language, predictable layout, supported communication, breaks, and sensory accommodations. Distinguish participant report from caregiver observations and proxy responses.
Overlapping groups	An autistic teenager would have one linked census record with the appropriate age and accessibility version. They would not be counted twice across cohorts.

Autism would be an accessibility and analysis consideration, not a presumed marker of electromagnetic susceptibility. The census would not diagnose autism or determine its cause. Self-reported sensory experiences and observable changes would be distinguished from baseline neurodevelopmental characteristics.

Proxy respondents would not be asked to infer unobservable sensations as though the participant had reported them. Not known and not applicable options would be available where needed, with explicit scoring rules. Child, caregiver, and supported self-report data would remain identifiable in analysis.

Participation would use appropriate guardian permission and assent procedures. Younger autistic children could enter only through a separately reviewed pediatric adaptation within the same A–B structure. Teenagers and autistic participants would not be assigned adult risk labels without validation.

Adaptations would be reviewed through cognitive interviews and a feasibility pilot before national release. A common item map would show which questions remain comparable and which require separate reporting. Version-specific totals would not be pooled merely because they share a scale label.

8 National Recruitment and Participation

Recruitment would invite participation across states and participating territories through universities, municipalities, schools, community organizations, healthcare networks, autism organizations, and general-public channels. Recruitment would include people with and without concerns about electromagnetic exposure.

The census would offer secure online completion, paper forms, telephone assistance, and accessible supported participation. English and Spanish versions would form an initial language set, with additional languages selected according to recruitment needs. A and B could be completed in one session or resumed securely without a third assessment.

Administrative fields would include consent status, a nonpublic linkage identifier, age or age band, broad geography, recruitment route, survey language, version, self-versus-proxy status, and dates. Identifying contact information for optional follow-up would be stored separately from analytical responses.

A broad voluntary census would describe its participants. If nationally representative estimates are requested, a probability-sampled component would be designed within the same program using only A and B. Sampling, selection probabilities, nonresponse, weights, and uncertainty would be documented; a large convenience sample alone does not establish population prevalence. [9]

9 Analysis and Public Reporting

- Report invitations where known, starts, A-only responses, B-only responses, linked pairs, exclusions, duplicates, and missing items.
- Publish A and B distributions and predefined symptom patterns by geography, age, version, and respondent type where sample size permits.
- Examine continuous habits–symptom associations and sensitivity-adjusted analyses using prespecified A domains.
- Report subgroup comparisons with uncertainty and multiple-testing control; separate self-report and proxy results.
- Describe selection and nonresponse limitations and assess the effect of incomplete pairs.
- Publish association and burden estimates without labeling them rates of confirmed electromagnetic disease.

Only participants with appropriately linked A and B records would enter paired analyses. Separate A and B response counts from the 2025 project would not be assumed to define the paired sample. The protocol would prespecify missing-item rules and prohibit coding an unanswered item as zero by default.

Repeated census waves could monitor changes in reported patterns. Incidence or progression claims would require linked longitudinal follow-up and a defined case endpoint, beyond a one-time score category.

10 Scientific Working Groups and Independence

EFEIA's Scientific Circle model provides a route to voluntary project-specific participation. A census working group would have a defined remit, named responsibilities where agreed, and independent methodological review. Receiving a bulletin or joining a private discussion would not be represented as endorsement. [2]

Working groups would address questionnaire and scoring control; survey design and statistics; teenager and autism accessibility; ethics and privacy; and reporting. Clinical advisors would review participant guidance and referral boundaries without converting the census into a clinical diagnostic examination.

EFEIA's relationship with the NOXTAK ecosystem and SPIRO would be disclosed. Census participation would be independent of product purchases or intervention enrollment. The program would evaluate A–B screening performance, not product effectiveness.

The 2014–2018 report would inform historical context, including the recognition of expectation-related responses. Its uncontrolled observations, concurrent interventions, earlier 29-item instrument, and limited causal inference would not be presented as national prevalence, diagnostic validation, or proof of product benefit. [5]

11 Data Protection and Quality Control

A governed data system would separate identifiers from survey answers, restrict access, record changes, and use explicit retention rules. Public maps would use aggregated geography and suppress small cells, especially for minors and small autism subgroups.

Participation would be voluntary, with clear research and data-use information. Existing forms state that collected information is confidential and not for commercial purposes; the national program would honor applicable commitments and establish consistent consent language. [8]

Quality checks would cover duplicates, eligibility, inconsistent answers, version mismatch, impossible scores, and automated or fraudulent entries. Legitimate severe responses would not be discarded simply because they are unusual. Exclusions and corrections would be logged and reported.

A and B would remain the only participant health questionnaires in the national census. Any later invitation for measurement, clinical assessment, or intervention research would require a distinct explanation and consent pathway.

12 Deliverable to Each Participant

A concise result would show the completed version, A and B scores where valid, principal reported domains, and a plain-language explanation of the screening profile. It would offer optional next steps and explain that the result records habits and symptoms rather than establishing their cause.

13 Two Year Implementation Schedule

Phase	Timing	Deliverables
Preparation	Months 1–6	Freeze A–B versions and item rules; reconcile legacy materials; review teenager and autism adaptations; establish governance; pilot accessibility and scoring; finalize recruitment and analysis.
National census	Months 7–18	Conduct twelve months of A–B collection through approved routes; maintain assistance, quality checks, linkage, and participation reporting.
Analysis and first report	Months 19–24	Close and reconcile the dataset; conduct prespecified analyses; complete independent review; publish the first national report and recommendations.

The initial sample target would be determined from precision requirements, planned subgroup comparisons, recruitment design, and resources. An arbitrary enrollment number would not substitute for the sampling and analysis plan. Pilot results would provide completion-time and cost estimates before full rollout.

14 Government Support Requested

EFEIA Foundation requests support for a national two-questionnaire screening initiative, including universities and community partners, accessible participation, independent statistical review, secure data infrastructure, and a first public report within two years.

- Authorize or fund a voluntary national A–B census pilot and expansion process.
- Support teenager and autism-accessible versions through appropriate expert review.
- Fund recruitment broad enough to include participants without preexisting EHS concerns.
- Require transparent scoring, version control, recruitment disclosures, and independent analysis.
- Support optional follow-up services and research separately from census participation.

The budget would cover coordination, instrument standardization, accessibility, survey delivery, outreach, data management, analysis, and independent review. It would not require environmental measurement equipment, a full clinical workup, or a product intervention for every census participant.

Closing Proposal

EFEIA and the NOXTAK Project bring an existing protocol and an extensive reported field history to a practical national proposal: ask how people use technology, ask which symptoms they experience, and analyze the relationship consistently. A national A–B census would make these patterns visible, guide follow-up, and create a stronger foundation for independent research.

Appendix Instrument Control and Evidence Register

The following decisions would be resolved during preparation while preserving the two-questionnaire scope.

Control item	Required decision
Authoritative A form	Reconcile the two-page Habits form with the workbook and Phase 1 presentation. Identify all items, answer options, and scoring rules in one controlled version.
A maximum and domains	Verify the achievable 106-point maximum. Separate technology habits, sensitivities, other lifestyle items, and symptom-like questions for analysis.
B response construct	Fix recall period and whether the 0–10 anchors measure frequency or intensity. Document any change from prior versions and its comparability limits.
A–B outputs	Retain separate totals and domain information. Do not apply the 519-point A+B+C composite or its bands to A and B alone.
Historical instruments	Map the earlier 29-symptom NOXTAK questionnaire to the current 25-item B without assuming equivalence or recalculating absent item data.
Population adaptations	Version teenager and autism-accessible forms; identify proxy answers; establish which items and scores support comparisons.
2025 report reconciliation	Confirm unique enrollment and linked A–B counts; resolve differing summary statistics and inconsistent denominators before reusing numerical claims.
Organizational history	Record the updated more-than-10,000-person account separately from documented study samples; define period, contact type, case terminology, and deduplication.

This proposal retains the existing EFEIA instruments as its foundation. It does not claim that the national A–B subset, proposed marker, or adapted versions have already achieved clinical diagnostic validity. The screening-versus-diagnosis distinction is particularly relevant because established EHS diagnostic criteria remain unresolved. [10]

The primary deliverables are a controlled A–B instrument, an accessible collection system, a linked dataset with transparent denominators, a reproducible analysis, and the first national report. Additional assessment remains available when warranted without expanding the mandatory census.

References and Source Materials

[1] EFEIA Foundation and NOXTAK organizational account supplied by Joaquin Machado on October 20 2026. More than ten years and more than 10,000 people, including reported electrosensitivity and psychological or contextual presentations. Organizational experience statement, distinct from audited study cohorts.

[2] EFEIA Scientific Circle & Working Groups. Supplied PowerPoint dossier, March 2026. Relevant sections: foundation and mission; evidence base; scientific-circle and project-specific working groups. Institutional claims are attributed to the dossier.

[3] EFEIA. El Protocolo EFEIA Fase 1. Supplied PowerPoint presentation. Questionnaire A and B domains and scoring; distinction between screening and diagnosis.

[4] EFEIA Phase 1 Scoring & Interpretation Workbook. Supplied Word file EFEIA Phase 1 — Scoring & Interpretation Workbook_1-2.docx. Item-level scoring and interpretation rules for the broader A+B+C protocol.

[5] Machado JJ and Leal R. Prevalence and Effects of Electrohypersensitivity Evaluating the Application of SPIRO in the Management of EHS in a Longitudinal Study of 357 Patients 2014–2018. March 2019 preprint; supplied PDF. doi:10.13140/RG.2.2.21974.11849.

[6] EFEIA Foundation. EHS Global Census 2025 Cross-Survey Analysis with Sensitivity Profiles. Supplied 27-page PDF, analysis dated December 15 2025.

[7] EFEIA Foundation. EHS Global Census 2025 Survey B 25 Common Symptoms of EHS. Supplied 25-page PDF, report dated December 15 2025.

[8] EFEIA. Habits and Multiple Sensitivities. Supplied two-page PDF questionnaire. Related context: Protocolo_EFEIA_Mejorado.pptx and The EFEIA Evaluation Protocol presentation supplied previously.

[9] US Centers for Disease Control and Prevention. BRFSS Frequently Asked Questions. Survey weighting and population-estimate methodology as a reference for design, not endorsement of this proposal. https://www.cdc.gov/brfss/about/brfss_faq.htm

[10] World Health Organization. Electromagnetic hypersensitivity. https://www.who.int/teams/environment-climate-change-and-health/radiation-and-health/non-ionizing/hypersensitivity

External methodological and clinical references reviewed October 20 2026. The source materials provide institutional experience and a protocol lineage; the national A–B design and adaptations are proposed implementation steps.