B

2025

EFEIA FOUNDATION

EHS Global Census

Survey B:
25 Common Symptoms of EHS

Report Date: December 15, 2025
Analysis Period: August 2025 - December 2025
Total Participants: 141
Survey Languages: Spanish (86.2%), English (13.8%)

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EHS GLOBAL CENSUS 2025
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Executive Summary

Survey B assessed symptom burden across 25 symptoms commonly associated with electromagnetic hypersensitivity, collecting data from 141 participants across 20+ countries. Each symptom was scored 0-10, yielding a total possible score of 0-250. This analysis provides critical insight into how EHS manifests at the population level.

Key Findings

- **Mean symptom burden:** 78.7/250 (31.5% of maximum)
- **Cognitive and autonomic symptoms dominate:** fatigue (5.94/10), concentration problems (5.15), nervousness (5.13), insomnia (5.08), irritability (4.95), and memory problems (4.86) occupy the top six positions
- **Classic EHS-characteristic symptoms rank far lower:** facial warmth (1.82), skin prickling (1.87), eyebrow pain (1.26)
- **Ratio of core functional to EHS-specific somatic symptoms:** 2.78:1

Key Statistics at a Glance

Metric	Value
Total Participants	141
Mean Symptom Score	78,7/250 (31.5%)
Median Score	73,0
Score Range	3 – 206
Mean Active Symptoms (≥4)	9,8
Mean Severe Symptoms (≥7)	5,2
Female Mean Score	85,3
Male Mean Score	61,8
Gender Difference	p=0.005 (significant)
Peak Age Group	31-45 (mean=91.6)
High Burden Population (Q5)	20%
Top Symptom	Fatigue (5.94/10)
Lowest Symptom	Eyebrow pain (1.26/10)

1. Purpose and Scope

Survey B is the second instrument in the EFEIA Three-Survey Protocol, designed to quantify symptom burden across multiple body systems in individuals concerned about electromagnetic field (EMF) exposure. The survey employs a standardized 0-10 severity scale for each of 25 symptoms, yielding a total score range of 0-250 points.

As stated in the EFEIA protocol: "*Survey B is positioned at the center of the EFEIA protocol, following the assessment of environmental exposure and lifestyle (Survey A) and before the physiological confirmation of sleep impairment (Survey C).*"

The survey answers the central question: ***"What symptoms are present — and how frequently — when this person is exposed to potential sources of EMR?"***

1.1 Symptom Categories

The survey covers six functional domains:

- **Neurological:** Dizziness, headaches, memory and concentration problems, irritability, nervousness, insomnia, racing head sensation.
- **Cardiovascular and Respiratory:** Arrhythmias, blood pressure problems, chest pressure, difficulty breathing.
- **Dermatological:** Facial redness, sensations of heat, tingling, rashes, itching
- **Auditory and Visual:** Tinnitus, hearing loss, ear pain, blurred vision.
- **Cognitive and Emotional:** Sleep disorders, short-term memory, emotional reactivity.
- **Somatosensory and Digestive:** Skin discomfort, irritable bowel syndrome, sensations of pressure or prickling.

1.2 Official Score Interpretation

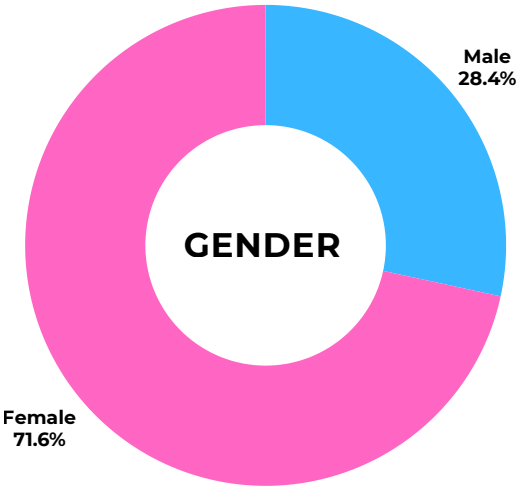
Per EFEIA protocol guidelines:

Category	Score Range	Clinical Interpretation
No clear EHS indications	0-39	No significant symptoms related to EMF exposure
Possible ES development	40-58	Mild symptoms that may be linked to EMF exposure
Intermittent Electro-Sensitivity	59-71	Symptoms appear inconsistently but are noticeable
Electro-Sensitivity (ES)	72-110	Frequent symptoms that affect daily life
Electrohypersensitivity (EHS)	111-250	Severe and persistent symptoms

Note: The total score is indicative. The symptom distribution pattern is equally or more relevant than the aggregate score.

2. Demographic Profile

2.1 Gender Distribution



Gender	n	%	Mean Score
Female	101	71,6%	85,3
Male	40	28,4%	61,8

Statistical analysis: t=2.828, p=0.005. Female participants report symptom scores approximately 38% higher than male participants.

2.2 Age Distribution

Mean: 44.8 years, **Median:** 45.0 years, **Std Dev:** 11.6 years, **Range:** 18-73 years

Key Insight:
The 31-45 group shows 58% higher burden than young adults (91.6 vs. 58.0) and 25% higher than those 46-60 (73.1). This midlife peak suggests EHS is driven by occupational exposure intensity rather than cumulative aging. The "vulnerability window" coincides with maximum screen time, smartphone dependence, and workplace EMF exposure combined with minimal recovery time.

Age Group	n	Mean Score	Interpretation
18-30	15	58,0	Lowest burden
31-45	59	91,6	Highest burden
46-60	52	73,1	Moderate burden
60+	14	69,1	Moderate burden

Age-Score Correlation: r=-0.058, p=0.497 — No significant linear relationship.

2.3 BMI Analysis

BMI Category	n	%	Mean Score	Median
Underweight	15	10,6%	102,6	82,0
Healthy weight	96	68,1%	72,7	69,0
Overweight	24	17,0%	77,0	63,0
Obese	6	4,3%	121,8	115,5

Key Finding: U-Shaped Relationship
BMI shows a U-shaped relationship with symptom burden: both underweight (mean=102.6) and obese (mean=121.8) individuals report significantly higher symptoms than healthy weight individuals (mean=72.7, p=0.021 and p=0.008 respectively). However, even among those meeting full EHS criteria (111-250), healthy weight individuals represent 58.8%, the majority. The extremes are overrepresented (underweight: 20.6% of EHS vs 10.6% of total sample; obese: 11.8% of EHS vs 4.3% of total), but EHS is not a condition exclusive to metabolic imbalance.

EHS Category	% Underweight	% Healthy	% Overweight	% Obese
No EHS	3,4%	93,1%	3,4%	0%
Developing/Intermittent	12,5%	**60,0%**	**27,5%**	0%
ES	5,4%	**67,6%**	**21,6%**	5,4%
EHS	**20,6%**	**58,8%**	8,8%	**11,8%**

This suggests:

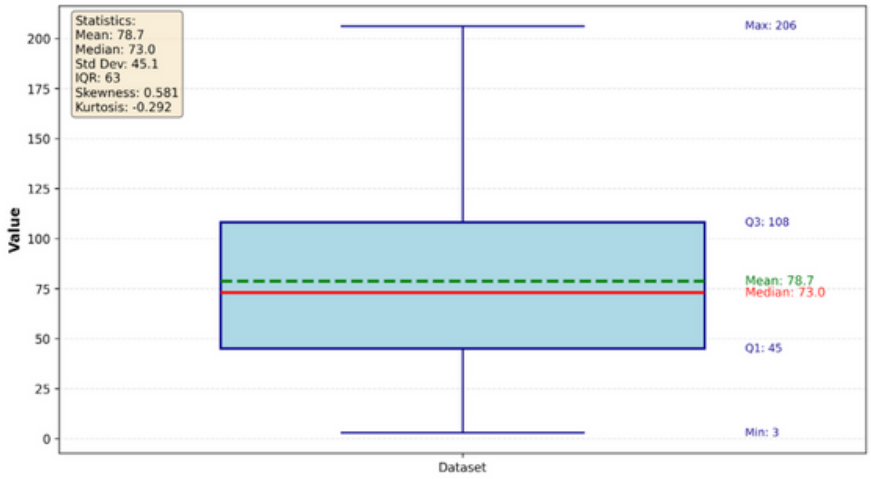
1. **Metabolic extremes may increase vulnerability**, but are not required for EHS development.
2. **EHS can affect anyone regardless of body composition:** the majority of severe cases are normal weight.
3. **When present in underweight/obese individuals, EHS tends to be more severe:** possible bidirectional relationship (EHS affecting metabolism, or shared underlying mechanisms like chronic inflammation, mast cell activation, or mitochondrial dysfunction).

Clinical implication: BMI extremes warrant attention as potential vulnerability markers, but healthy weight does not confer protection against EHS.

3. Total Symptom Score Analysis

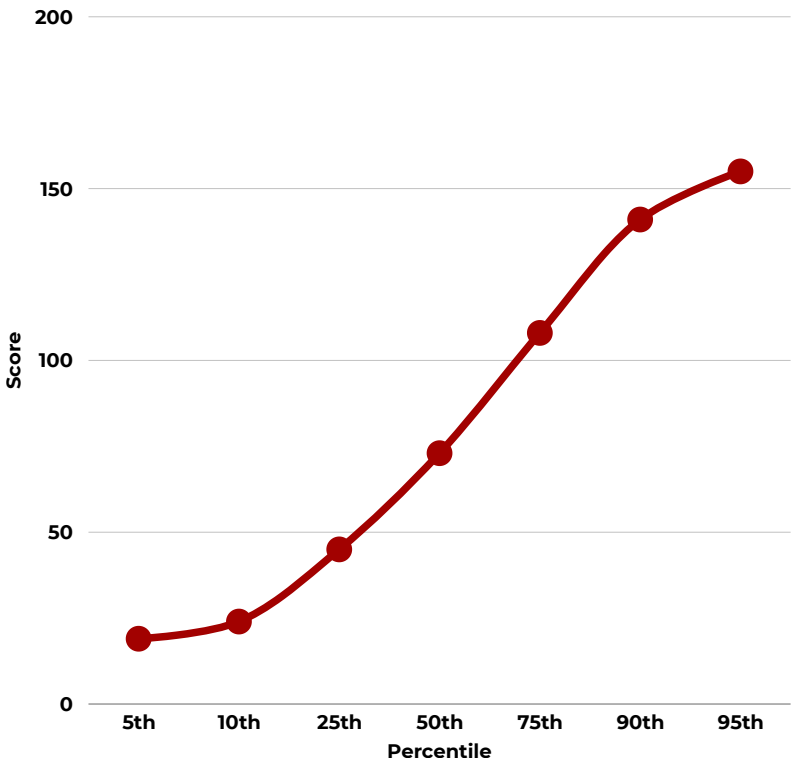
3.1 Distribution Statistics

Statistic	Value
Mean	78,7
Median	73,0
Std Dev	45,1
Range	3-206
IQR	45-108
Skewness	0,581
Kurtosis	-0,292



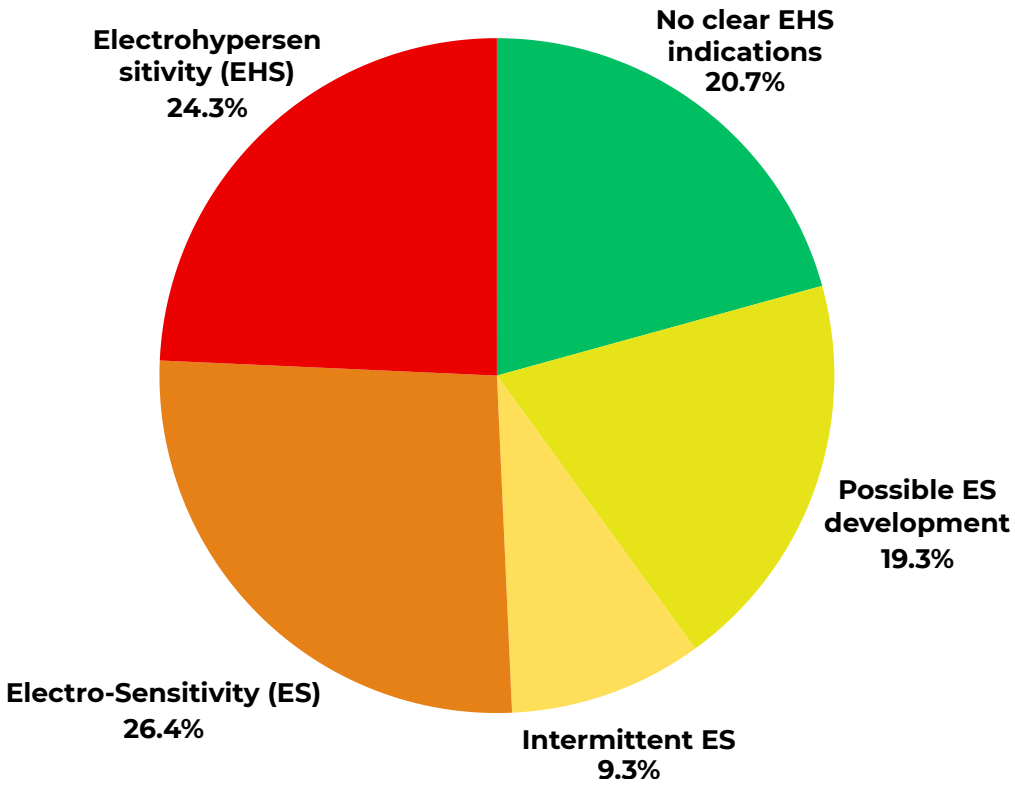
3.2 Percentile Distribution

Percentile	Score
5th	19
10th	24
25th	45
50th	73
75th	108
90th	141
95th	155



3.3 Distribution by Categories

Category	Score Range	n	%
No clear EHS indications	0-39	29	20,7%
Possible ES development	40-58	27	19,3%
Intermittent ES	59-71	13	9,3%
Electro-Sensitivity (ES)	72-110	37	26,4%
Electrohypersensitivity (EHS)	111-250	34	24,3%



Critical Finding: 79.3% show some indication of ES/EHS (score >39).

4. Individual Symptom Analysis

4.1 Symptom Severity Ranking (by mean score)

Rank	Symptom	Mean	Median	SD	% Low (0-3)	% Mid (4-6)	% Severe (7-10)
1	Fatigue	5,94	6,0	2,90	24,1%	27,7%	48,2%
2	Concentration problems	5,15	5,0	3,03	32,6%	29,8%	37,6%
3	Nervousness	5,13	6,0	2,82	31,2%	30,5%	38,3%
4	Insomnia	5,08	5,0	3,09	35,5%	26,2%	38,3%
5	Irritability	4,95	5,0	2,72	33,3%	30,5%	36,2%
6	Memory problems	4,86	5,0	3,16	36,9%	29,1%	34,0%
7	Headache	3,82	3,0	3,08	52,5%	23,4%	24,1%
8	Skin problems	3,67	3,0	3,17	52,5%	22,0%	25,5%
9	Head pressure/numbness	3,40	3,0	3,38	56,7%	22,0%	21,3%
10	Blurred vision	3,04	3,0	3,08	60,3%	22,7%	17,0%
11	Hypersomnia	2,97	1,0	3,40	63,8%	14,2%	22,0%
12	Irritable bowel	2,85	0,0	3,59	65,2%	14,2%	20,6%
13	Tight band around head	2,71	1,0	3,30	67,4%	12,8%	19,9%
14	Tinnitus	2,68	2,0	3,06	69,5%	17,0%	13,5%
15	Dizziness	2,68	1,0	2,95	63,8%	19,9%	16,3%
16	Tachycardia/Arrhythmia	2,52	2,0	2,90	68,8%	17,0%	13,5%
17	Chest pressure	2,28	1,0	2,83	70,9%	16,3%	12,8%
18	Lack of oxygen feeling	2,26	1,0	2,77	73,8%	14,2%	12,1%
19	Facial redness/swelling	2,08	0,0	3,13	73,8%	13,5%	12,8%
20	Hearing loss	1,92	0,0	2,74	77,3%	12,1%	10,6%
21	Blood pressure problems	1,87	0,0	2,80	77,3%	11,3%	11,3%
22	Skin prickling	1,87	0,0	2,73	78,0%	12,8%	9,2%
23	Facial warmth	1,82	0,0	2,82	83,0%	7,1%	9,9%

Rank	Symptom	Mean	Median	SD	% Low (0-3)	% Mid (4-6)	% Severe (7-10)
24	**Ear pain**	1,37	0,0	2,32	85,8%	7,1%	7,1%
25	**Eyebrow pain**	1,26	0,0	2,43	85,8%	7,1%	7,1%

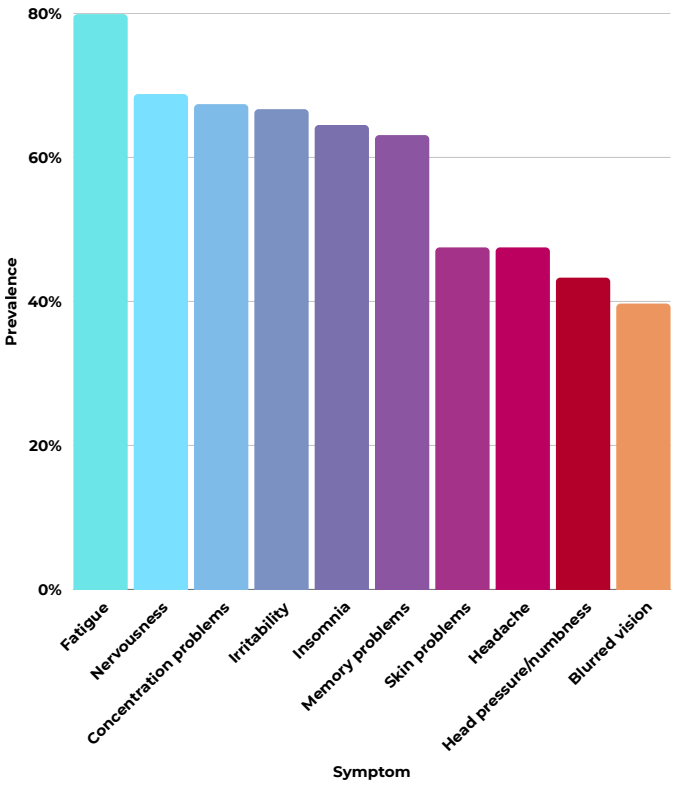
Symptom Tiers

- **Tier 1 — High Burden (Mean ≥4.5):** Fatigue, Concentration, Nervousness, Insomnia, Irritability, Memory problems Cognitive-autonomic cluster dominates — over 1/3 report severe levels.
- **Tier 2 — Moderate Burden (Mean 2.5-4.5):** Headache, Skin problems, Head pressure, Blurred vision, Hypersomnia, Irritable bowel, Tight band, Tinnitus, Dizziness, Tachycardia Mixed neurological, sensory, and somatic symptoms.
- **Tier 3 — Low Burden (Mean <2.5):** Chest pressure, Lack of oxygen, Facial redness, Hearing loss, Blood pressure, Skin prickling, Facial warmth, Ear pain, Eyebrow pain Classic EHS-characteristic symptoms rank lowest — majority report minimal/no presence.

Key Observation: The top 6 symptoms are all cognitive-autonomic (fatigue, concentration, nervousness, insomnia, irritability, memory). The bottom 9 symptoms include most classic EHS markers (facial warmth, skin prickling, eyebrow pain). This inversion, where functional symptoms dominate over somatic EHS markers, reinforces that EHS manifests primarily as central nervous system dysfunction rather than peripheral tissue response.

4.2 Symptom Prevalence (% scoring ≥4)

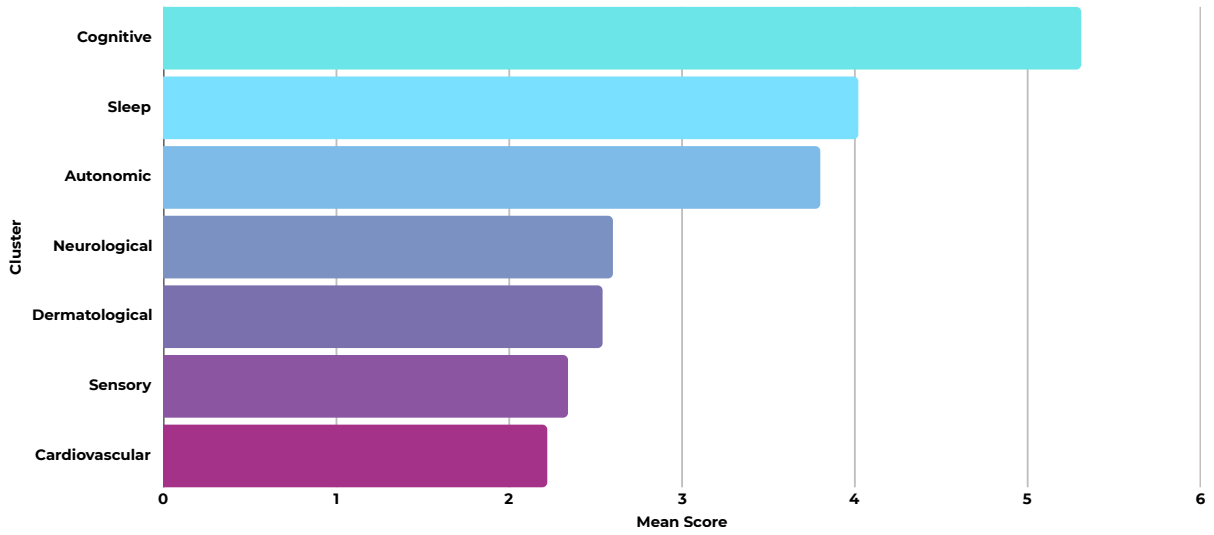
Symptom	Prevalence
Fatigue	79,9%
Nervousness	68,8%
Concentration problems	67,4%
Irritability	66,7%
Insomnia	64,5%
Memory problems	63,1%
Skin problems	47,5%
Headache	47,5%
Head pressure/numbness	43,3%
Blurred vision	39,7%



5. Symptom Cluster Analysis

5.1 Cluster Mean Scores

Cluster	Mean Score	Symptoms
Cognitive	5,31	Fatigue, Concentration, Memory
Sleep	4,02	Insomnia, Hypersomnia
Autonomic	3,80	Nervousness, Irritability, Lack of oxygen, IBS
Neurological	2,60	Headache, Head pressure, Tight band, Eyebrow pain, Facial warmth
Dermatological	2,54	Skin problems, Skin prickling, Facial redness
Sensory	2,34	Tinnitus, Ear pain, Hearing loss, Blurred vision, Dizziness
Cardiovascular	2,22	Tachycardia, Blood pressure, Chest pressure



5.2 Core vs. EHS-Characteristic Symptoms

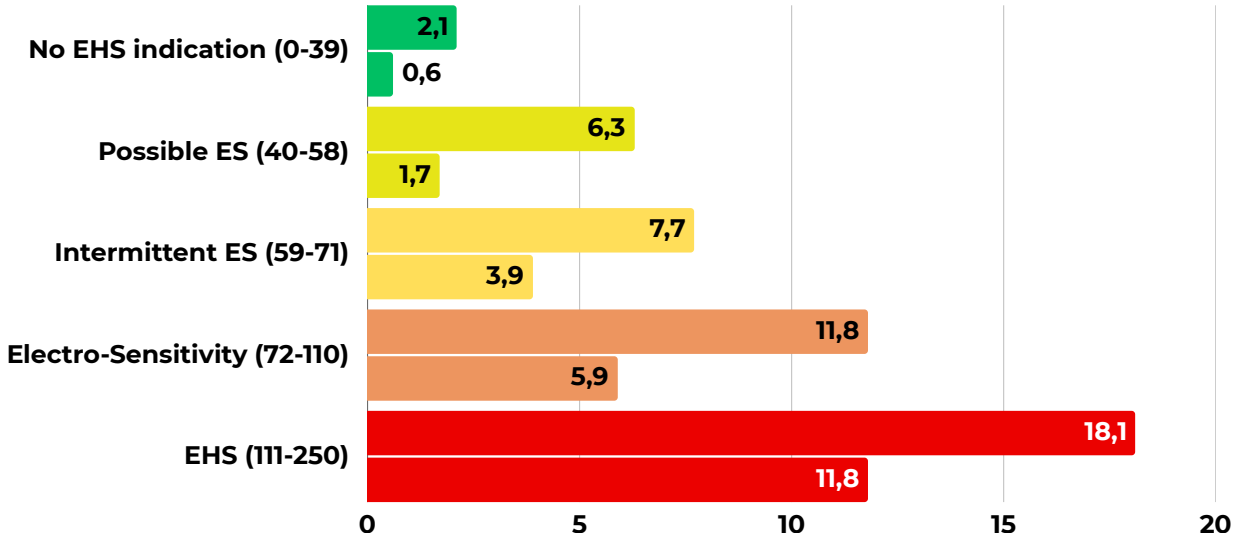
Cluster	Symptoms	Mean
Core/General	Fatigue, Insomnia, Concentration, Memory, Headache, Nervousness	5,00
EHS-Characteristic	Head pressure, Tight band, Facial warmth, Tinnitus, Skin prickling, Concentration	2,94

Ratio: 2.78:1

6. Symptom Profile by Category

6.1 Progression Across Categories

Category	n	Mean Score	Active Symptoms (≥4)	Severe Symptoms (≥7)
No EHS indication (0-39)	29,00	24,1	2,1	0,6
Possible ES (40-58)	27,00	49,3	6,3	1,7
Intermittent ES (59-71)	13,00	65,4	7,7	3,9
Electro-Sensitivity (72-110)	37,00	88,6	11,8	5,9
EHS (111-250)	34,00	**143,0**	**18,1**	**11,8**



6.2 Top Symptoms by Category

- **No EHS indication (0-39):** Fatigue (3.0), Irritability (2.6), Insomnia (2.6).
- **Possible ES development (40-58):** Fatigue (4.5), Nervousness (4.4), Irritability (4.1).
- **Intermittent ES (59-71):** Fatigue (6.2), Insomnia (6.2), Nervousness (5.0).
- **Electro-Sensitivity (72-110):** Fatigue (6.9), Memory problems (6.6), Nervousness (6.5).
- **Electrohypersensitivity (111-250):** Fatigue (8.6), Concentration problems (7.8), Memory problems (7.5).

Pattern: Fatigue leads across all categories. As severity increases, cognitive symptoms (concentration, memory) rise in prominence alongside neurological symptoms (headache, head pressure).

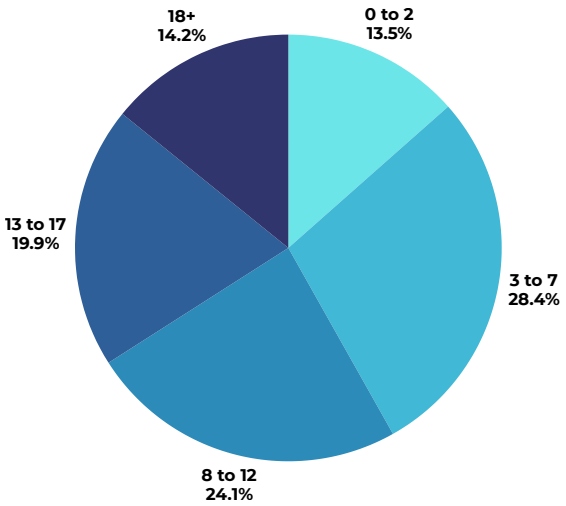
7. Symptom Active Count Analysis

7.1 Number of Active Symptoms (scored ≥4)

Statistic	Value
Mean	9.8 symptoms
Median	9.0 symptoms
Range	0 – 23

Distribution:

Statistic	n	%
0 to 2	19	13,5%
3 to 7	40	28,4%
8 to 12	34	24,1%
13 to 17	28	19,9%
18+	20	14,2%

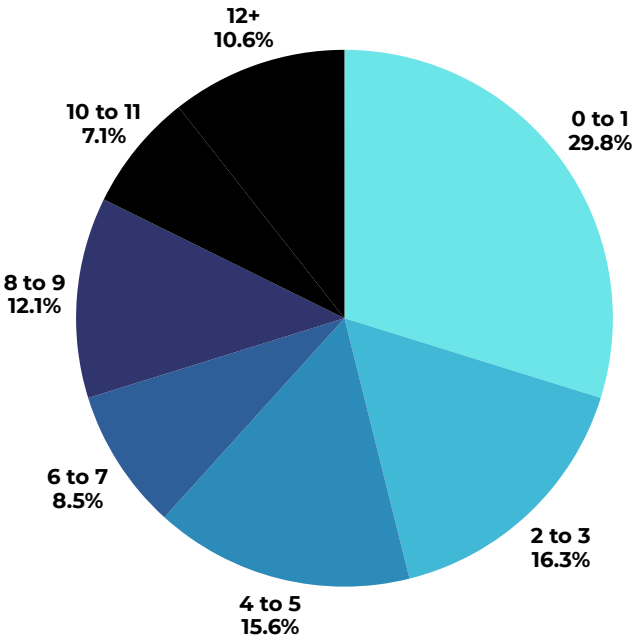


7.2 Severe Symptoms (scored 7-10)

Statistic	Value
Mean	5,2 severe symptoms
Median	4 severe symptoms

Distribution:

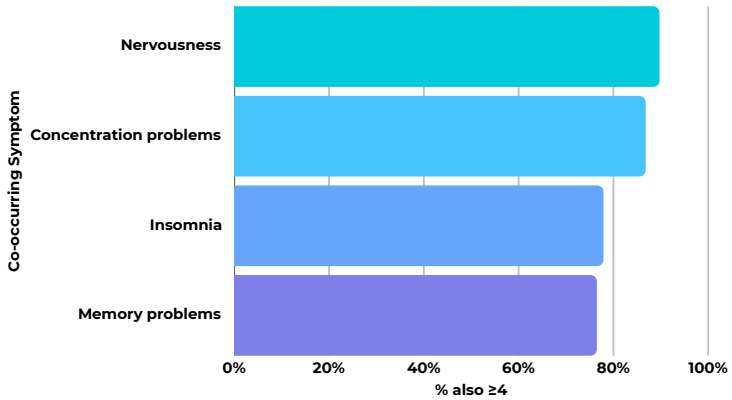
Statistic	n	%
0 to 1	42	29,8%
2 to 3	23	16,3%
4 to 5	22	15,6%
6 to 7	12	8,5%
8 to 9	17	12,1%
10 to 11	10	7,1%
12+	15	10,6%



8. Symptom Co-Occurrence Patterns

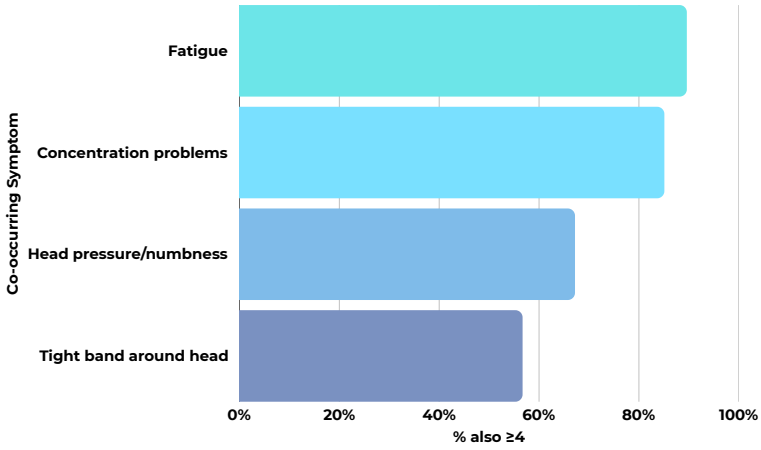
8.1 When Fatigue is Severe (≥7) — n=68

Co-occurring Symptom	% also ≥4
Nervousness	89,7%
Concentration problems	86,8%
Insomnia	77,9%
Memory problems	76,5%



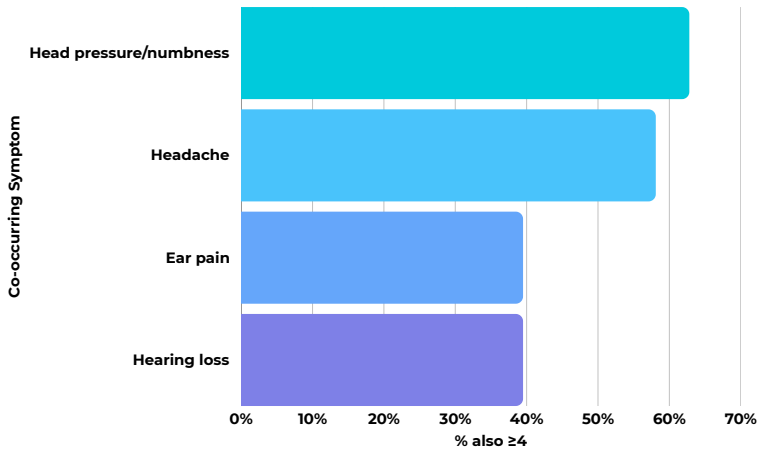
8.2 When Headache is Active (≥4) — n=67

Co-occurring Symptom	% also ≥4
Fatigue	89,6%
Concentration problems	85,1%
Head pressure/numbness	67,2%
Tight band around head	56,7%



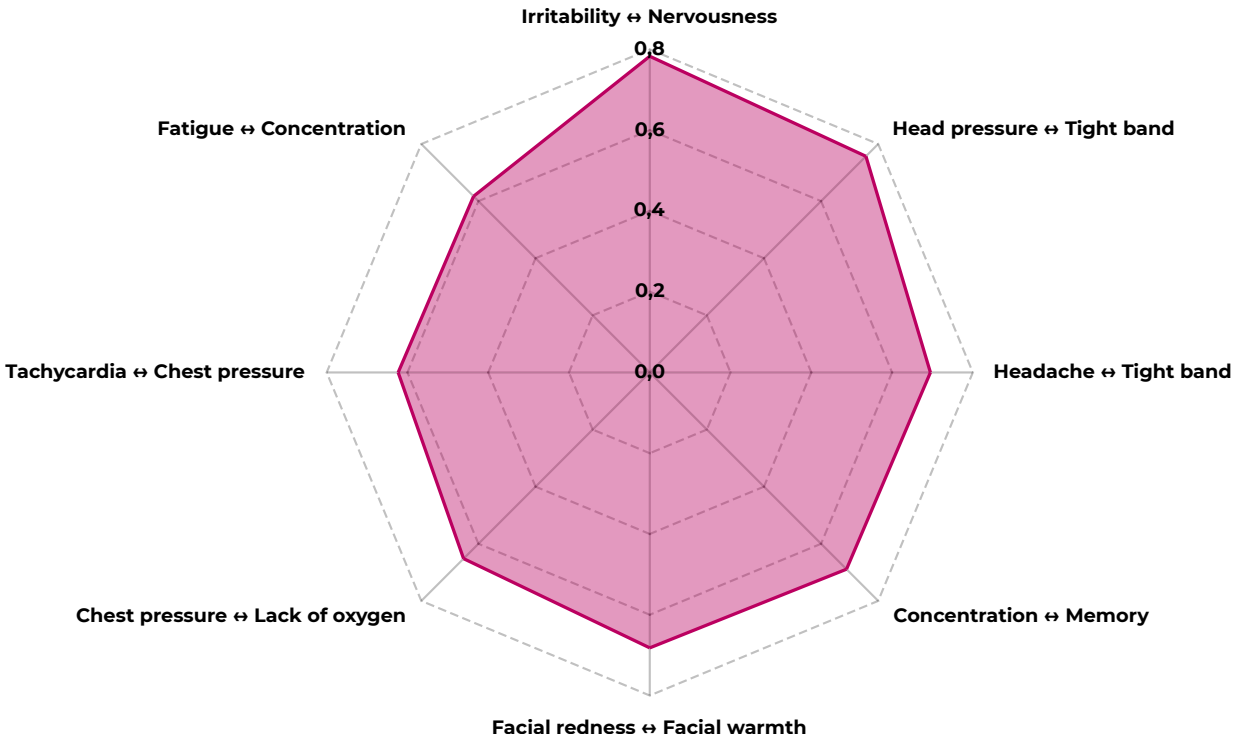
8.3 When Tinnitus is Active (≥4) — n=43

Co-occurring Symptom	% also ≥4
Head pressure/numbness	62,8%
Headache	58,1%
Ear pain	39,5%
Hearing loss	39,5%



8.4 Strongest Symptom Correlations

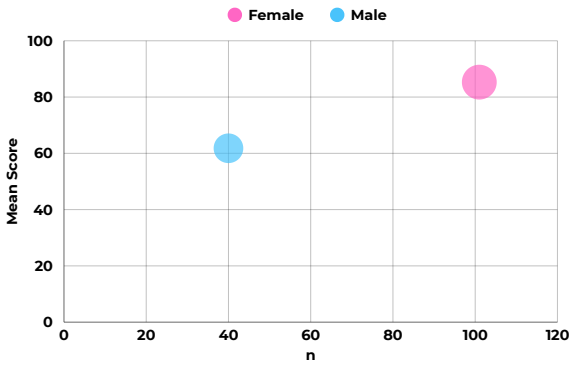
Statistic	r
Irritability ↔ Nervousness	0,783
Head pressure ↔ Tight band	0,757
Headache ↔ Tight band	0,695
Concentration ↔ Memory	0,689
Facial redness ↔ Facial warmth	0,682
Chest pressure ↔ Lack of oxygen	0,652
Tachycardia ↔ Chest pressure	0,623
Fatigue ↔ Concentration	0,617



9. Gender Analysis

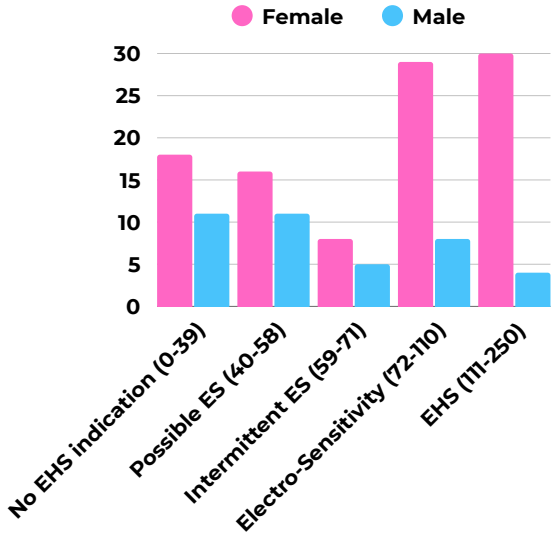
9.1 Overall Gender Difference

Gender	n	Mean Score	Median	Active Symptoms
Female	101	85,3	79,0	10,8
Male	40	61,8	54,5	7,2



9.2 Gender Distribution by Category

Category	Female	Male	Female %
No EHS indication (0-39)	18	11	62%
Possible ES (40-58)	16	11	59%
Intermittent ES (59-71)	8	5	62%
Electro-Sensitivity (72-110)	29	8	78%
EHS (111-250)	30	4	88%



Critical Finding: Female representation increases dramatically with severity. In the EHS category, females outnumber males nearly 8:1 (30 vs. 4).

9.3 Implications

The gender disparity intensifying with severity suggests:

- **Possible biological vulnerability** (hormonal, genetic, or immunological factors)
- **Higher female prevalence of overlapping conditions** (fibromyalgia, chronic fatigue, MCAS)
- **Differential exposure patterns**

This is not explained by reporting bias alone: the magnitude and pattern demand investigation.

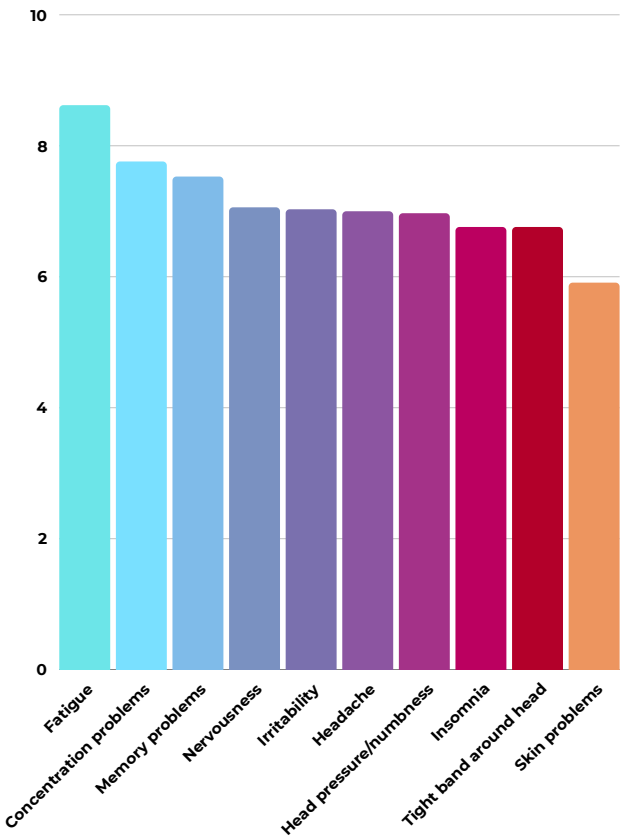
10. EHS Category Deep Dive (Score 111-250)

10.1 Overview

Statistic	Value
n	34
% of Total Sample	21,1%
Mean Score	143,0
Score Range	113 - 206
Mean Active Symptoms	18,1 (of 25)
Mean Severe Symptoms	11,8
Female	30 (88%)
Male	4 (12%)
Mean Age	43,1 years

10.2 Top 10 Symptoms in EHS Group

Rank	Symptom	Mean Score
1	**Fatigue**	8,62
2	**Concentration problems**	7,76
3	**Memory problems**	7,53
4	**Nervousness**	7,06
5	**Irritability**	7,03
6	**Headache**	7,00
7	**Head pressure/numbness**	6,97
8	**Insomnia**	6,76
9	**Tight band around head**	6,76
10	**Skin problems**	5,91



10.3 EHS Profile Interpretation

The EHS group presents a distinct clinical picture:

- **Near-total cognitive involvement:** fatigue, concentration, and memory all exceed 7.5/10.
- **Prominent neurological cluster:** headache, head pressure, tight band all score 6.7-7.0.
- **Multi-system engagement:** average of 18 active symptoms indicates polysymptomatic condition.
- **Overwhelmingly female:** 88% of EHS cases.
- **Peak working age:** mean age 43.1 years.

This profile aligns with the EFEIA protocol description of severe EHS as involving "*chronic nervous system excitation triggered by EMR, sleep deprivation, or electro-induced neuroinflammation.*"

Discussion

Population Stratification

Based on official EFEIA categories, the population divides into clinically meaningful groups:

No Clear EHS Indication (20.6%)
- **Score:** 0-39
- 2.1 active symptoms, 0.6 severe
- May represent early exposure, successful management, or low sensitivity
- Baseline monitoring recommended

Developing/Intermittent ES (28.4%)
- **Score:** 40-71
- 6-8 active symptoms, 2-4 severe
- Symptoms emerging but inconsistent
- Prime candidates for early intervention and EMF hygiene education

Electro-Sensitivity (26.2%)
- **Score:** 72-110
- 11.8 active symptoms, 5.9 severe
- Frequent symptoms affecting daily life
- Require systematic EMF reduction protocols

Electrohypersensitivity (24.1%)
- **Score:** 111-250
- 18.1 active symptoms, 11.8 severe
- Severe, persistent, multi-system illness
- Require comprehensive intervention and clinical support

The Cognitive-Autonomic Dominance Pattern

The most significant finding is the clear dominance of cognitive and autonomic symptoms over classic EHS-characteristic somatic symptoms. Fatigue, concentration problems, nervousness, insomnia, irritability, and memory problems occupy the top six positions, all scoring above 4.8/10; while symptoms traditionally associated with EHS literature such as facial warmth (1.82), skin prickling (1.87), and eyebrow pain (1.26) rank among the lowest.

This pattern aligns with the our protocol description of neurological dominance suggesting "*EMR exposure may be affecting the central or autonomic nervous system, particularly in individuals with prior neurological vulnerability.*"

The 2.78:1 ratio between core/general symptoms and EHS-characteristic symptoms suggests that EHS manifests primarily as a functional disorder affecting daily performance, work capacity, and quality of life, symptoms that are invisible to external observers and may be dismissed in clinical settings.

The Sleep-Cognition Nexus

The co-occurrence analysis reveals a tightly bound cluster: when fatigue reaches severe levels (≥7), 89.7% also report significant nervousness, 86.8% report concentration problems, 77.9% report insomnia, and 76.5% report memory problems.

With 64.5% of participants reporting clinically significant insomnia, sleep disruption emerges as a potential central mediating variable. Our protocol notes that insomnia is associated with "disruption of circadian rhythms and melatonin production" from "nighttime Wi-Fi, LED screens before bed, router in bedroom."

If sleep disruption is indeed the linchpin, it carries significant clinical implications: sleep-focused interventions, including nighttime EMF reduction as emphasized in the LEDNA framework, may produce outsized benefits across the entire symptom profile.

Gender Disparity: A Profound Finding

The 38% higher overall symptom burden in females (85.3 vs. 61.8, p=0.005) is highly significant, but the pattern across severity categories is extraordinary:

- **No EHS indication:** 62% female.
- **Possible ES:** 59% female.
- **Intermittent ES:** 62% female.
- **Electro-Sensitivity:** 78% female.
- **EHS:** 88% female.

This gradient, from roughly equal representation in mild cases to 8:1 female dominance in severe cases, cannot be dismissed as reporting bias. It suggests either:

- Biological vulnerability that becomes critical at higher exposure/sensitivity levels.
- Hormonal factors amplifying symptom expression or progression.
- Differential exposure patterns (domestic vs. occupational).
- Overlapping vulnerability with female-predominant conditions (fibromyalgia, chronic fatigue, MCAS).

The EFEIA protocol notes that dermatological symptoms may indicate "mast cell activation, histamine intolerance", conditions with strong female predominance that may represent underlying mechanisms.

The 31-45 Age Peak

The pronounced symptom burden peak in the 31-45 age group (mean=91.6 vs. 58.0 for 18-30 and 73.1 for 46-60) suggests a window of maximum vulnerability during peak occupational years.

The EFEIA protocol associates cognitive symptoms with chronic EMR exposure, especially in sesitized individuals or people with pre-existing health conditions; also noting that neurological dominance is "typical in people exposed to screens for many hours, especially at night."

The 31-45 window represents maximum convergence of:

- Screen time and smartphone dependence.
- Office/workplace EMF exposure.
- Work-related stress.
- Family responsibilities limiting recovery time.

The EHS Subset: A Distinct Clinical Population

The 34 participants (24.1%) meeting EHS criteria (score >110) represent a qualitatively different population. With 18.1 active symptoms and 11.8 at severe levels, these individuals experience a polysymptomatic condition affecting nearly every assessed domain.

Their symptom profile, led by fatigue (8.62), concentration problems (7.76), memory problems (7.53), and prominently including neurological symptoms (headache 7.00, head pressure 6.97, tight band 6.76), aligns with the EFEIA protocol description of severe EHS involving "*central sensitization or visceral hypersensitivity, a hallmark of chronic EMR exposure*."

The 88% female composition and mean age of 43.1 years further characterize this group as requiring distinct clinical approaches.

Symptom Clustering: Coherent Syndromes

The inter-symptom correlations reveal coherent pathophysiological clusters:

- **Autonomic/Mood (r=0.783):** Reflects unified autonomic dysregulation.
- **Cranial/Vascular (r=0.695-0.757):** Suggests cranial nerve or vascular mechanism.
- **Cognitive (r=0.617-0.689):** Points to central processing impairment.
- **Cardiorespiratory (r=0.623-0.652):** Indicates autonomic/vagal involvement.

The EFEIA protocol notes that "symptom distribution matters as much as overall severity" and that "*a specific group may report early-stage EMR syndrome, specific system sensitivity, or environmental factors that uniquely affect that part of the body.*"

These clusters support development of phenotype-specific intervention protocols rather than uniform approaches.

Limitations

Several limitations constrain interpretation:

- Self-selected sample likely overrepresents symptomatic individuals.
- Cross-sectional design cannot establish causality.
- Self-reported symptom severity lacks objective validation.
- Absence of control group prevents comparison with general population base rates.
- Survey B becomes fully meaningful only when interpreted with Survey A (exposure) and Survey C (sleep).

As the EFEIA protocol states: "*Because symptom reporting is inherently subjective, Survey B becomes meaningful only when interpreted in terms of lifestyle (Survey A) and sleep (Survey C).*"

Conclusion

Key Findings

The Survey B analysis of 141 participants reveals:

1. **Clear stratification by categories:** 20.6% show no EHS indication, 28.4% show developing/intermittent sensitivity, 26.2% meet Electro-Sensitivity criteria, and 24.1% meet full Electrohypersensitivity criteria.
2. **Cognitive-autonomic symptom dominance:** Fatigue, concentration problems, nervousness, and insomnia constitute the core burden, with over 60% reporting clinically significant levels.
3. **Profound gender disparity:** Females represent 88% of EHS cases, increasing from 62% in mild categories to nearly 8:1 in severe cases.
4. **Age vulnerability window:** The 31-45 age group shows peak burden (mean=91.6), reflecting maximum occupational EMF exposure during prime working years.
5. **Coherent symptom clusters:** Inter-symptom correlations reveal organized pathophysiological groupings supporting phenotype-specific intervention.

Clinical Implications

- Use official EFEIA 5-tier classification for general stratification.
- **Screen for cognitive symptoms first:** fatigue, concentration, and memory are the most reliable indicators.
- **Prioritize sleep intervention:** the sleep-cognition cascade suggests high-leverage benefit from nighttime EMF reduction.
- **Recognize gender vulnerability:** female subjects, especially ages 31-45, require heightened attention.
- **Match intervention to severity:** the 24.1% EHS population requires different intensity than developing cases.

Research Implications

- **Integrate with Survey A and C:** symptom burden must be interpreted against exposure patterns and sleep disruption.
- **Investigate gender mechanism:** the 88% female finding in severe EHS demands biological explanation.
- **Track category transitions:** longitudinal monitoring of progression and response to intervention.
- **Validate cluster-based protocols:** test whether phenotype-specific approaches outperform uniform treatment.

Summary Statement

Survey B establishes that electromagnetic hypersensitivity in the EHS Global Census population is real, measurable, and stratifiable. Nearly 80% of participants show some indication of electro-sensitivity, with 24.1% meeting criteria for severe, persistent electrohypersensitivity. The symptom profile is coherent rather than random, clustering into identifiable syndromes with cognitive-autonomic symptoms at the core.

The profound gender disparity, with females representing 88% of severe cases, and the age vulnerability window at 31-45 years provide critical demographic insights for both clinical practice and research design.

These findings validate the EFEIA Evaluation Protocol as a systematic framework for assessment and provide the quantitative foundation for evidence-based intervention strategies in electromagnetic hypersensitivity.

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