

DETOXIFICATION QUESTIONNAIRE

Patient Name: _____

Date: _____

Rate each of the following symptoms based on your typical health profile for the specified duration:

Past month Past week Past 48 hours

Point Scale: **0**—Never or almost never have the symptom **1**—Occasionally have it, effect is not severe **2**—Occasionally have it, effect is severe
3—Frequently have it, effect is not severe **4**—Frequently have it, effect is severe

I. Medical Symptoms Questionnaire (MSQ)

HEAD	_____ Headaches	
	_____ Faintness	
	_____ Dizziness	
	_____ Insomnia	TOTAL _____
EYES	_____ Watery or itchy eyes	
	_____ Swollen, reddened or sticky eyelids	
	_____ Bags or dark circles under eyes	
	_____ Blurred or tunnel vision	TOTAL _____
EARS	_____ Itchy ears	
	_____ Earaches, ear infections	
	_____ Drainage from ear	
	_____ Ringing in ears, hearing loss	TOTAL _____
NOSE	_____ Stuffy nose	
	_____ Sinus problems	
	_____ Hay fever	
	_____ Sneezing attacks	
	_____ Excessive mucus formation	TOTAL _____
MOUTH/ THROAT	_____ Chronic coughing	
	_____ Gagging, frequent need to clear throat	
	_____ Sore throat, hoarseness, loss of voice	
	_____ Swollen or discolored tongue, gums, lips	
	_____ Canker sores	TOTAL _____
SKIN	_____ Acne	
	_____ Hives, rashes, dry skin	
	_____ Hair loss	
	_____ Flushing, hot flashes	
	_____ Excessive sweating	TOTAL _____
HEART	_____ Chest pain	
	_____ Irregular or skipped heartbeat	
	_____ Rapid or pounding heartbeat	TOTAL _____
LUNGS	_____ Chest congestion	
	_____ Asthma, bronchitis	
	_____ Shortness of breath	
	_____ Difficulty breathing	TOTAL _____
DIGESTIVE TRACT	_____ Nausea, vomiting	
	_____ Diarrhea	
	_____ Constipation	
	_____ Bloating feeling	
	_____ Belching, passing gas	
	_____ Heartburn	
	_____ Intestinal/stomach pain	TOTAL _____
JOINTS/ MUSCLE	_____ Pain or aches in joints	
	_____ Arthritis	
	_____ Stiffness or limitation of movement	
	_____ Feeling of weakness or tiredness	
	_____ Pain or aches in muscles	TOTAL _____
WEIGHT	_____ Binge eating/drinking	
	_____ Craving certain foods	
	_____ Excessive weight	
	_____ Water retention	
	_____ Underweight	
	_____ Compulsive eating	TOTAL _____
ENERGY/ ACTIVITY	_____ Fatigue, sluggishness	
	_____ Apathy, lethargy	
	_____ Hyperactivity	
	_____ Restlessness	TOTAL _____
MIND	_____ Poor memory	
	_____ Confusion, poor comprehension	
	_____ Difficulty in making decisions	
	_____ Stuttering or stammering	
	_____ Slurred speech	
	_____ Learning disabilities	
	_____ Poor concentration	
	_____ Poor physical coordination	TOTAL _____
EMOTIONS	_____ Mood swings	
	_____ Anxiety, fear, nervousness	
	_____ Anger, irritability, aggressiveness	
	_____ Depression	TOTAL _____
OTHER	_____ Frequent illness	
	_____ Frequent or urgent urination	
	_____ Genital itch or discharge	TOTAL _____
GRAND TOTAL		TOTAL _____

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?

Yes (1 pt.)

If yes, how many are you currently taking? _____ (1 pt. each)

No (0 pt.)

2. Are you presently taking one or more of the following over-the-counter drugs?

Cimetidine (2 pts.)

Acetaminophen (2 pts.)

Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:

Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)

Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)

Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)

Experience *no* side effects, drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?

Yes (2 pts.) No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?

Yes (1 pt.) No (0 pt.) Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?

Yes (1 pt.) No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?

Yes (1 pt.) No (0 pt.) Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?

Yes (1 pt.) No (0 pt.) Don't know (0 pt.)

10. Do you have a personal history of

Environmental and/or chemical sensitivities (5 pts.)

Chronic fatigue syndrome (5 pts.)

Multiple chemical sensitivity (5 pts.)

Fibromyalgia (3 pts.)

Parkinson's type symptoms (3 pts.)

Alcohol or chemical dependence (2 pts.)

Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?

Yes (1 pt.) No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?

Yes (1 pt.) No (0 pt.) Don't know (0 pt.)

GRAND TOTAL: _____

III. Alkalizing Assessment

1. Do you have a history or currently have kidney dysfunction?

Yes No

2. Have you ever been diagnosed with a condition known as hyperkalemia?

Yes No

3. Are you currently on diuretics or blood pressure medication?

Yes No

Note: Prescribe non-alkalizing nutrients if patient answered yes to any part of this section.

For Practitioner Use Only:

OVERALL SCORE TABULATION

See doctor brochure for protocol suggestions.

MSQ SCORE _____ (High >50; moderate 15-49; Low <14)

XTT SCORE _____ (High >10; moderate 5-9; Low <4)

URINARY pH _____

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfunction, oxidative stress, hormonal/neuro-transmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.