

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.