

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

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?

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

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

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.