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	
	_____	Bloated 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?

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 dysfuntion, oxidative stress, hormonal/neuro-transmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.