DETOXIFICATION QUESTIONNAIRE

Name:	Date:	
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Rate each of the following symptoms based on your typical health profile:

Point scale: 0—never or almost never have the symptom **1**—Occasionally have it; effects not severe **2**—occasionally have it; effects severe **3**—Frequently have it; effects not severe **4**—Frequently have it; effects severe

Medical Symptoms Questionnaire (MSQ)						
HEAD	Headaches Faintness Dizziness Insomnia Watery or itchy eyes Swollen, reddened or s		DIGEST- IVE TRACT	Pain or aches in joints Arthritis Stiffness or limitation of me Feeling of weakness or tire Belching/passing gas Heartburn Intestinal/stomach pains	edness	
	Bags or dark circles un Blurred or tunnel vision		JOINTS/ MUSCLE	Pain or aches in joints Arthritis Stiffness or limitation of me	ovement	
EARS _	Itchy ears Earaches, ear infection Drainage from ears	s	-	Feeling of weakness or tire Pain or aches in muscles	edness	
	Ringing in ears, hearing loss	TOTAL	WEIGHT _	Binge eating / drinking Craving certain foods Excessive weight		
NOSE _ _ _	Stuffy nose Sinus problems Hay fever Sneezing attacks			Water retention Underweight	TOTAL _	
_	Excessive mucus forma	ation TOTAL	ENERGY/ ACTIVITY	Fatigue, sluggishness Apathy, lethargy Hyperactivity		
MOUTH/ _ THROAT _ - -	Chronic coughing Gagging, frequent need Sore throat, hoarsenes Swollen or discolored to gums, lips Canker sores	s, voice loss	MIND _	Poor memory Confusion, poor comprehe Difficulty in making decision Stuttering or stammering		
SKIN	AcneHives, rashes, dry skinHair lossFlushing hot flashes Excessive sweating	TOTAL	-	Slurred speech Learning disabilities Poor concentration Poor physical coordination	TOTAL _	
HEART _	Chest painIrregular or skipped heaRapid or pounding hea	artbeat	EMOTIONS	Mood swingsAnxiety, fear, nervousnessAnger, irritability, aggressivDepression		
LUNGS _ - - -	Chest congestion Asthma, bronchitis Shortness of breath Shortness of breath Difficulty breathing	TOTAL	OTHER	Frequent illness Frequent or urgent urination Genital itch or discharge		

2. XENOBIOTIC TOLERABILITY TEST (XTT)							
Are you presently using prescription drugs? ☐ Yes (1 pt) If yes, how many are you currently taking? (1 pt each) ☐ No (0 pts)	6. Do you commonly experience "brain fog," fatigue, or drowsiness? ☐ Yes (1 pt) ☐ No (0 pts) 7. Do you develop symptoms on exposure to						
2. Are you presently taking one or more of the following over-the-counter drugs?□ Cimetidine (2 pts)	fragrances, exhaust fumes, or strong odors? Yes (1 pt) No (0 pts) Don't know (0 pts) 8. Do you feel ill after you consume even small amounts of alcohol? Yes (1 pt) No (0 pts) Don't know (0 pts)						
☐ Acetaminophen (2 pts) ☐ Estradiol (2 pts)							
3. If you have used or currently use prescription drugs, which of the following scenarios best represent 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 <i>no</i> side effects, drug(s) is (are) usually <i>not</i> efficacious. (2 pts) ☐ Experience <i>no</i> side effects, drug(s) is (are)	9. Do you have a personal history of Environmental and/or chemical sensitivities (5 p Chronic fatigue syndrome (5 pts) Multiple chemical sensitivities (5 pts) Fibromyalgia (3 pts) Parkinson's type symptoms (3 pts) Alcohol or chemical dependence (2 pts) Asthma (1 pt)						
usually efficacious. (0 pts) 4. Do you currently use or within the last 6 months have you regularly used tobacco products? □ Yes (2 pts) □ No (0 pts)	 10. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents? ☐ Yes (1 pt) ☐ No (0 pts) 						
5. Do you have strong negative reactions to caffeine or caffeine-containing products? ☐ Yes (1 pt) ☐ No (0 pts) ☐ Don't know (0 pts)	 11. Do you have a history of adverse or allergic reaction when you consume sulfite-containing foods such as wine, dried fruit, salad bar vegetables, etc? ☐ Yes (1 pt) ☐ No (0 pts) ☐ Don't know (0 pts) 						
	GRAND TOTAL:						
3. ALKALIZING ASSESSMENT							
Do you have a history or currently have kidney dysfunction? ☐ Yes ☐ No	3. Are you currently on diuretics or blood pressure medication? ☐ Yes ☐ No						
2. Have you ever been diagnosed with a condition known as hyperkalemia?☐ Yes ☐ No	NOTE: Prescribe non-alkalizing nutrients if patient answered yes to any part of this section.						
For practitioner use only:	RE TABULATION						
MSQ SCORE (High > 50; moderate 15 - 49; low < 14) XTT SCORE (High > 10; moderate 5 - 9; low < 4) Urinary pH							