DETOXIFICATION QUESTIONAIRE

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 in *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 invoice
_____ Swollen or discoloured tongue, gums, lips
_____ Canker Sores **TOTAL** _____

DIGESTIVE TRACK
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
TOTAL _____

JOINTS/ MUSCLE
_____ Pains or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Feeling of weakness or tiredness
_____ Pains 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** _____

SKIN _____ Acne

_____ Hives, rashes, dry skin

_____ Hair Loss

_____ Flushing, hot flashes

_____ Excessive sweating **TOTAL** _____

HEART _____ Chest Pain

_____ Irregular or skipped heart beat

_____ Rapid or pounding heartbeat

TOTAL _____

LUNGS _____ Chest congestion

_____ Asthma, bronchitis

_____ Shortness of breath

_____ Difficulty breathing **TOTAL** _____

MIND _____ Poor Memory

_____ Confusion, poor concentration

_____ 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. Xenobiotix 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 using 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.)

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

☐ Yes (1 pt.) ☐ No (0pt)

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

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

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

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

9. 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 (2pts)
- ☐ Asthma (1 pt)

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

☐ Yes (1 pt.) ☐ No (0pt)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?
☐ Yes (2 pts.) ☐ No (0pt)

5. Do you have strong negative reactions to caffeine or caffeine containing products?
☐ Yes (1 pt.) ☐ No (0pt) ☐ Don't know (0 pt)

11. Do you have an adverse or allergic reaction when you consume sulfite containing foods such wine, dried fruit, salad bar vegetables, etc?
☐ Yes (1 pt.) ☐ No (0pt) ☐ Don't know (0 pt)

GRAND TOTAL **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.

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.