

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

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. Alkalinizing 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-alkalinizing 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.