



# 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)

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

## 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?

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.