## **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   |           | DIGESTIVE Nausea, vomiting |  |  |  |

| HEAD   | Headaches                              | DIGESTIVE   | Nausea, vomiting                             |
|--------|--|-------------|--|
| ΠΕΑD   | Faintness                              | TRACT       | — Nausea, voluning<br>— Diarrhea             |
|        | Paritiess Dizziness                    |             | Constipation                                 |
|        | Insomnia TOTAL                         |             | Bloated feeling                              |
| EYES   | Watery or itchy eyes                   | =   -       | Belching, passing gas                        |
| EIES   | Swollen, reddened or sticky            | _           | Heartburn                                    |
|        | eyelids                                | _           | Intestinal/stomach pain <b>TOTAL</b> _       |
|        | ———— Bags or dark circles under eyes   | JOINTS/     | Pain or aches in joints                      |
|        | Blurred or tunnel vision <b>TOTAL</b>  | = MUSCLE    | Arthritis                                    |
| EARS   | Itchy ears                             |             | Stiffness or limitation of movement          |
|        | Earaches, ear infections               |             | — Feeling of weakness or tiredness           |
|        | Drainage from ear                      |             | —— Pain or aches in muscles <b>TOTAL</b>     |
|        | ———— Ringing in ears,                  |             | Binge eating/drinking                        |
|        | hearing loss TOTAL                     |             | Craving certain foods                        |
| NOSE   | — Stuffy nose                          |             | Excessive weight                             |
|        | — Sinus problems                       |             | — Water retention                            |
|        | ——— Hay fever                          |             | Underweight                                  |
|        | Sneezing attacks                       |             | Compulsive eating TOTAL_                     |
|        | Excessive mucus formation <b>TOTAL</b> |             | Fatigue, sluggishness                        |
| MOUTH/ | Chronic coughing                       |             | Apathy, lethargy                             |
| THROAT | Gagging, frequent need to clear throat |             | Hyperactivity                                |
|        | Sore throat, hoarseness,               |             | Restlessness TOTAL _                         |
|        | loss of voice                          | MIND        | — Poor memory                                |
|        | Swollen or discolored                  |             | Confusion, poor comprehension                |
|        | tongue, gums, lips                     |             | — Difficulty in making decisions             |
|        | Canker sores TOTAL                     | =           | Stuttering or stammering                     |
| SKIN   | Acne                                   |             | Slurred speech                               |
|        | Hives, rashes, dry skin                | _           | — Learning disabilities                      |
|        | Hair loss                              | _           | —— Poor concentration                        |
|        | Flushing, hot flashes                  | _           | —— Poor physical coordination <b>TOTAL</b> _ |
|        | Excessive sweating TOTAL               | EMOTIONS    | Mood swings                                  |
| HEART  | Chest pain                             | _           | Anxiety, fear, nervousness                   |
|        | Irregular or skipped heartbeat         |             | Anger, irritability, aggressiveness          |
|        | Rapid or pounding                      | _           | Depression <b>TOTAL</b> _                    |
| TIMOS  | heartbeat TOTAL                        | OTHER       | Frequent illness                             |
| LUNGS  | Chest congestion                       | _           | Frequent or urgent urination                 |
|        | Asthma, bronchitis Shortness of breath | _           | Genital itch or discharge <b>TOTAL</b> _     |
|        |  |             |  |
|        | — Difficulty breathing <b>TOTAL</b>    | 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? | 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.) |  |  |  |  |
| $\square$ Yes (1 pt.) $\square$ No (0 pt.) $\square$ Don't know (0 pt.)   | GRAND TOTAL:  |  |  |  |  |
| III. Alkalizing Assessment  |   |  |  |  |  |
| <ol> <li>Do you have a history or currently have kidney dysfunction?</li> <li>Yes  No</li> <li>Have you ever been diagnosed with a condition known as hyperkalemia?</li> </ol>  | 3. Are you currently on diuretics or blood pressure medication?  — Yes — No  Note: Prescribe non-alkalizing nutrients if patient answered yes to  |  |  |  |  |
| ☐ Yes ☐ No  | any part of this section.   |  |  |  |  |
| For Practitioner Use Only:  |   |  |  |  |  |
| OVERALL SCORE TABULATION  |   |  |  |  |  |
|   | (High >50; moderate 15-49: Low <14) (High >10; moderate 5-9: Low <4)  |  |  |  |  |
|   |   |  |  |  |  |

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.