Natural & Digestive Health, LLC
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DETOXIFICATION QUESTIONNAIRE

Client 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 Scales: 0 – Never or almost never have the symptoms 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
____ 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 muscus formation **TOTAL_____**

MOUTH/ THROAT
____Chronic coughing
____Gagging, frequent need to clear throat
____Sore throat, hoarseness, loss of voice
____Swollen or discolored tongue, gums, lips
____Canker sores **TOTAL_____**

SKIN
____Acne
____ Hives, rashes, dry skin
____Hair loss
____Flushing, hot flashes
____Excessive sweating **TOTAL_____**

HEART
____Chest pain
____Irregular or skipped heartbeat
____Rapid or pounding heartbeat **TOTAL _____**

LUNGS
____Chest congestion
____Asthma, bronchitis
____Shortness of breath
____Difficulty breathing **TOTAL_____**

DIGESTIVE TRACT
____Nausea, vomiting
____Diarrhea
____Constipation
____Bloated feeling
____ Belching, passing gas
____Heartburn
____Intestinal/stomach pain **TOTAL_____**

JOINTS/ MUSCLE
____ Pain or aches in joints
____ Arthritis
____ Stiffness or limitation of movement
____Feeling of weakness or tiredness
____ Pain 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_____**

MIND
____Poor memory
____Confusion, poor comprehension
____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 _____**

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Metabolic Detoxification Questionnaire

Part 2: 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 (within the last 6 months) or have 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 with 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.)

Total _____

Part 3: Alkalizing Assessment

1. **Do you have a history of or currently have kidney dysfunction?**
○ Yes (1 pt.) ○ No (0 pt.)

2. **Have you ever been diagnosed with hyperkalemia?**
○ Yes (1 pt.) ○ No (0 pt.)

3. **Are you currently taking diuretics or blood pressure medication?**
○ Yes (1 pt.) ○ No (0 pt.)

Total _____

Overall Score Tabulation

For Practitioner Use Only:

Part 1: Symptoms Grand Total _____ (High >50; moderate 15-49; low <14)
Part 2: XTT Total _____ (High >10; moderate 5-9; low <4)
Part 3: Alkalizing Assessment Total _____ (High ≥1)
Urinary pH _____

Notes:

- Patients with high symptoms but low XTT may be exhibiting reactions that are not related to toxic load. Other mechanisms should be considered, such as inflammation/immune/allergy, gastrointestinal dysfunction, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.
- Recommend non-alkalizing nutrients if patient answers "yes" to any questions in the Alkalizing Assessment.

Disclaimer: This questionnaire is for informational purposes only. It is not meant to diagnose or treat any condition or illness. All medical symptoms should be addressed by a qualified medical professional.