DETOXIFICATION QUESTIONNAIRE

Client Name: ______________________________ Date: __________

Rate each of the following symptoms based on your typical health profile for the past one to two months:

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. SYMPTOMS QUESTIONNAIRE (SQ)

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
______ Ringing in ears, hearing loss
______ Drainage from ear Total ______

NOSE
______ Stuffy nose
______ Sinus problems
______ Hay fever
______ Excessive mucus formation
______ Sneezing attacks 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 heart 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 in 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 physical coordination
______ Poor concentration Total ______

EMOTIONS
______ Mood Swings
______ Anxiety, fear, nervousness
______ Anger, irritability, aggressiveness

OTHER
______ Frequent illness
______ Frequent or urgent urination
______ Genital itch or discharge Total ______

GRAND TOTAL Total ______

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II. Toxic Load Test (TLT)

1. Are you presently using prescriptions drugs?
☐ Yes (1pt.)
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 represent your response to them:
☐ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3pts.)
☐ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2pts.)
☐ Experience no side effects, drug(s) is (are) usually not efficacious (2pts.)
☐ Experience *no* side effects, drug(s) is (are) usually efficacious (0pts.)

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 pts.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

6. Do you commonly experience "brain fog", fatique or drowsiness?
☐ Yes (1pt.) ☐ No (0 pt.)

7. Do you develop symptons on exposure to fragrances, exhaust fumes, or strong odors?
☐ Yes (1pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
☐ Yes (1pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

9. Do you have a personal history of
☐ Environmental and/or chemical sensitives (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.)

10. 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.)

11. 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 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

OVERALL SCORE TABULATION

SQ SCORE _________ (High >50; moderate 15-49: Low <14)
TLT SCORE _________ (High >10; moderate 5-9: Low <4)

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