

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

<p>1. Are you presently using prescription drugs? <input type="checkbox"/> Yes (1 pt.) If yes, how many are you currently taking? ____ (1 pt. each) <input type="checkbox"/> No (0 pt.)</p> <hr/> <p>2. Are you presently taking one or more of the following over-the-counter drugs? <input type="checkbox"/> Cimetidine (2 pts.) <input type="checkbox"/> Acetaminophen (2 pts.) <input type="checkbox"/> Estradiol (2 pts.)</p> <hr/> <p>3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them: <input type="checkbox"/> Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.) <input type="checkbox"/> Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.) <input type="checkbox"/> Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.) <input type="checkbox"/> Experience <i>no</i> side effects, drug(s) is (are) usually efficacious (0 pt.)</p> <hr/> <p>4. Do you currently use or within the last 6 months had you regularly used tobacco products? <input type="checkbox"/> Yes (2 pts.) <input type="checkbox"/> No (0 pt.)</p> <hr/> <p>5. Do you have strong negative reactions to caffeine or caffeine containing products? <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p>	<p>6. Do you commonly experience "brain fog," fatigue, or drowsiness? <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.)</p> <hr/> <p>7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors? <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p> <hr/> <p>8. Do you feel ill after you consume even small amounts of alcohol? <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p> <hr/> <p>10. Do you have a personal history of <input type="checkbox"/> Environmental and/or chemical sensitivities (5 pts.) <input type="checkbox"/> Chronic fatigue syndrome (5 pts.) <input type="checkbox"/> Multiple chemical sensitivity (5 pts.) <input type="checkbox"/> Fibromyalgia (3 pts.) <input type="checkbox"/> Parkinson's type symptoms (3 pts.) <input type="checkbox"/> Alcohol or chemical dependence (2 pts.) <input type="checkbox"/> Asthma (1 pt.)</p> <hr/> <p>11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents? <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.)</p> <hr/> <p>12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc? <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p> <p>GRAND TOTAL: _____</p>
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For Practitioner Use Only:

OVERALL SCORE TABULATION					
Recommended protocols based on new detoxification questionnaire (MSQ and XTT)					
		MSQ SCORE _____ (High >50; moderate 15-49; Low <14)			
		XTT SCORE _____ (High >10; moderate 5-9; Low <4)			
MSQ Score	XTT Score	Description	Functional Medicine Protocol		
			Medical Food	Diet	Additional Nutraceutical Support
50 or >	10 or >	High level of general symptoms and indicated symptoms of elevated toxic load	Medical food for imbalanced detoxifiers	28-day elimination diet	Bifunctional, antioxidant, and chlorophyllin nutraceuticals
15-49	5-9	Moderate level of general symptoms with moderate symptoms of toxic load	Medical food for imbalanced detoxifiers	10-day elimination diet	Consider bifunctional, antioxidant, and chlorophyllin nutraceuticals
14 or <	4 or <	Low level of general symptoms and minimal indicators of toxic load			Maintenance
Additional Symptom-Specific Support					
Symptom	Nutraceutical Support				
Water retention and/or frequent or urgent urination	Kidney support nutraceuticals				
Heartburn and/or intestinal/stomach pain	Functional dyspepsia nutraceuticals				
Diarrhea, constipation, and/or intestinal/stomach pain	Probiotics				

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/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.