Metabolic Detoxification Questionnaire

Part 1: Symptoms

Name: ______________________________ Date: ______________

Rate each of the following symptoms based on the last week using the point scale below:

0 Never or rarely 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

Category	Symptom	Rating
Digestive Tract	Nausea, vomiting	⓪ ① ② ③ ④
	Diarrhea	⓪ ① ② ③ ④
	Constipation	⓪ ① ② ③ ④
	Bloated feeling	⓪ ① ② ③ ④
	Heartburn	⓪ ① ② ③ ④
	Intestinal, stomach pain	⓪ ① ② ③ ④
	Digestive Total:	0
Joints / Muscles	Pain or aches in joints	⓪ ① ② ③ ④
	Arthritis, joint swelling	⓪ ① ② ③ ④
	Stiff or limitation of movement	⓪ ① ② ③ ④
	Pain or aches in muscles	⓪ ① ② ③ ④
	Feeling of weakness or tired	⓪ ① ② ③ ④
	Joints / Muscles Total:	0
Emotional	Mood swings	⓪ ① ② ③ ④
	Anxiety, fear, nervousness	⓪ ① ② ③ ④
	Anger, irritability, aggression	⓪ ① ② ③ ④
	Depression	⓪ ① ② ③ ④
	Emotional Total:	0
Weight / Food	Binge eating, drinking	⓪ ① ② ③ ④
	Craving certain foods	⓪ ① ② ③ ④
	Excessive weight	⓪ ① ② ③ ④
	Compulsive eating, food addictions	⓪ ① ② ③ ④
	Water retention	⓪ ① ② ③ ④
	Underweight	⓪ ① ② ③ ④
	Weight / Food Total:	0
Energy / Sleep	Fatigue, sluggishness	⓪ ① ② ③ ④
	Apathy, lethargy	⓪ ① ② ③ ④
	Hyperactivity	⓪ ① ② ③ ④
	Restlessness, achiness	⓪ ① ② ③ ④
	Sleep disturbances	⓪ ① ② ③ ④
	Energy / Sleep Total:	0
Skin	Acne	⓪ ① ② ③ ④
	Hives, rashes, dry skin, redness	⓪ ① ② ③ ④
	Hair loss	⓪ ① ② ③ ④
	Flushing, hot flashes	⓪ ① ② ③ ④
	Excessive sweating	⓪ ① ② ③ ④
	Skin Total:	0
Heart	Irregular or skipped heartbeat	⓪ ① ② ③ ④
	Rapid or pounding heartbeat	⓪ ① ② ③ ④
	Chest pain	⓪ ① ② ③ ④
	Heart Total:	0
Other	Frequent illness	⓪ ① ② ③ ④
	Frequent or urgent urination	⓪ ① ② ③ ④
	Genital itch or discharge	⓪ ① ② ③ ④
	Other Total:	0
Respiratory	Chest congestion	⓪ ① ② ③ ④
	Asthma, bronchitis	⓪ ① ② ③ ④
	Shortness of breath	⓪ ① ② ③ ④
	Difficulty breathing	⓪ ① ② ③ ④
	Respiratory Total:	0
Eyes	Watery or itchy eyes	⓪ ① ② ③ ④
	Swollen, red, or sticky eyelids	⓪ ① ② ③ ④
	Bags or dark circles under eyes	⓪ ① ② ③ ④
	Blurred or restricted vision	⓪ ① ② ③ ④
	Eyes Total:	0
Nose	Stuffy nose	⓪ ① ② ③ ④
	Sinus problems or dripping nose	⓪ ① ② ③ ④
	Hay fever	⓪ ① ② ③ ④
	Sneezing attacks	⓪ ① ② ③ ④
	Excessive mucus	⓪ ① ② ③ ④
	Nose Total:	0
Mouth / Throat	Frequent, consistent coughing	⓪ ① ② ③ ④
	Gagging, need to clear throat	⓪ ① ② ③ ④
	Sore throat, hoarse, loss of voice	⓪ ① ② ③ ④
	Swollen or discolored tongue, gums, or lips	⓪ ① ② ③ ④
	Canker sores, other mouth sores	⓪ ① ② ③ ④
	Mouth / Throat Total:	0
Ears	Itchy ears	⓪ ① ② ③ ④
	Earaches, ear infections	⓪ ① ② ③ ④
	Drainage from ear, waxy buildup	⓪ ① ② ③ ④
	Ringing in ears, hearing loss	⓪ ① ② ③ ④
	Ears Total:	0
Head	Headaches	⓪ ① ② ③ ④
	Faintness or lightheadedness	⓪ ① ② ③ ④
	Dizziness	⓪ ① ② ③ ④
	Head Total:	0
Cognitive	Poor memory, recall	⓪ ① ② ③ ④
	Confusion, poor comprehension	⓪ ① ② ③ ④
	Poor concentration	⓪ ① ② ③ ④
	Poor physical coordination	⓪ ① ② ③ ④
	Difficulty in making decisions	⓪ ① ② ③ ④
	Stuttering, stammering	⓪ ① ② ③ ④
	Slurred speech	⓪ ① ② ③ ④
	Learning disabilities	⓪ ① ② ③ ④
	Cognitive Total:	0

Grand Total 0

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 0

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 0

Overall Score Tabulation

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.