DETOXIFICATION QUESTIONNAIRE

Patient Name: _____

Rate each symptom you've experienced during the: ☐ Past month ☐ Past week ☐ Past 48 hours

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

Point Scale:

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

Head

Headaches _____ Faintness _____ Dizziness _____ Insomnia _____

Total _____

Lungs

Chest Congestion _____ Asthma, Bronchitis _____ Shortness of breath _____ Difficulty breathing _____

Total _____

Eyes

Watery or itchy eyes _____ Swollen, reddened or sticky eyelids _____

Bags or dark circles under eyes _____ Blurred or tunnel vision _____

Total _____

Skin

Acne _____ Hives, rashes, dry skin _____ Hair loss or new hair growth _____

Flushing, hot flashes _____ Excessive sweating _____

Total _____

Ears

Itchy ears _____ Ear aches, ear infections _____

Drainage from ears _____ Ringing in ears, hearing loss _____

Total _____

Joints/Muscle

Pain or aches in joints _____ Arthritis _____ Stiffness or limitation of movement _____

Feeling weakness or tiredness _____ Pain or aches in muscles _____

Total _____

Nose

Stuffy nose _____ Sinus problems _____ Hay fever _____

Sneezing attacks _____ Excessive mucus formation _____

Total _____

Weight

Binge eating/drinking _____ Craving certain foods _____ Excessive weight _____

Water retention _____ Underweight _____ Compulsive eating _____

Total _____

Mouth/Throat

Chronic coughing _____ Gagging, frequent need to clear throat _____ Canker sores _____

Sore throat, hoarseness, loss of voice _____ Swollen or discolored tongue, gums, lips _____

Total _____

Energy/Activity

Fatigue, sluggishness _____ Apathy, lethargy _____ Hyperactivity _____ Restlessness _____

Total _____

Digestive Tract

Nausea, vomiting _____ Diarrhea _____ Constipation _____ Bloated feeling _____

Belching, passing gas _____ Heartburn _____ Intestinal/stomach pain _____

Total _____

Mind

Poor memory _____ Learning disability _____ Difficulty in making decisions _____

Stuttering or stammering _____ Slurred speech _____ Poor concentration _____

Confusion, poor comprehension _____ Poor physical coordination _____

Total _____

Heart

Chest pain _____ Irregular or skipped heartbeat _____ Rapid or pounding heartbeat _____

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 (MSQ) _____

XENOBIOTIC TOLERABILITY TEST (XTT) SCORE

1. Are you presently using prescription drugs? Yes (1 point). If yes, how many are you currently taking? (1 point for each) _____

2. Are you presently taking one or more of the following over-the counter drugs: Antacids (2 points), Tylenol (2 points), Birth control pill or hormone replacement therapy (2 points) _____

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
   a. I experience side effects and the drug is efficacious at lowered doses (3 points)
   b. I experience side effects and the drug is efficacious at usual doses (2 points)
   c. I experience no side effects and the drug is usually not efficacious (2 points)
   d. I experience no side effects and the drug is usually efficacious (O points) _____

4. Do you currently use or within the last 6 months had you regularly used tobacco products? Yes (2 points) _____

5. Do you have strong reactions to caffeine or caffeine containing products? Yes (1 point) _____

6. Do you commonly experience “brain fog,” fatigue, or drowsiness? Yes (1 point) _____

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors? Yes (1 point) _____

8. Do you feel ill after you consume even small amounts of alcohol? Yes (1 point) _____

9. Do you have a personal history of: Environmental and/or chemical sensitivities (5 points) Chronic fatigue syndrome (5 points) Multiple chemical sensitivity (5 points) Fibromyalgia (3 points) Parkinson’s type symptoms (3 points) Alcohol or chemical dependence (2 points) Asthma (1 point) _____

10. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents? Yes (1 point) _____

11. Do you have an adverse or allergic reaction when you consume sulfite-containing foods such as wine, dried fruit or salad bar vegetables? Yes (1 point) _____

GRAND TOTAL (XTT): _____