

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