

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

Digestive Tract	Nausea, vomiting	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Diarrhea	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Constipation	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Bloated feeling	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Heartburn	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Intestinal, stomach pain	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

Digestive Total:

Joints / Muscles	Pain or aches in joints	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Arthritis, joint swelling	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Stiff or limitation of movement	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Pain or aches in muscles	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Feeling of weakness or tired	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

Joints / Muscles Total:

Emotional	Mood swings	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Anxiety, fear, nervousness	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Anger, irritability, aggression	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Depression	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

Emotional Total:

Weight / Food	Binge eating, drinking	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Craving certain foods	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Excessive weight	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Compulsive eating, food addictions	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Water retention	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Underweight	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

Weight / Food Total:

Energy / Sleep	Fatigue, sluggishness	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Apathy, lethargy	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Hyperactivity	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Restlessness, achiness	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Sleep disturbances	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

Energy / Sleep Total:

Skin	Acne	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Hives, rashes, dry skin, redness	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Hair loss	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Flushing, hot flashes	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Excessive sweating	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

Skin Total:

Heart	Irregular or skipped heartbeat	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Rapid or pounding heartbeat	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Chest pain	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

Heart Total:

Other	Frequent illness	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Frequent or urgent urination	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Genital itch or discharge	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

Other Total:

Respiratory	Chest congestion	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Asthma, bronchitis	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Shortness of breath	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Difficulty breathing	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

Respiratory Total:

Eyes	Watery or itchy eyes	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Swollen, red, or sticky eyelids	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Bags or dark circles under eyes	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Blurred or restricted vision	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

Eyes Total:

Nose	Stuffy nose	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Sinus problems or dripping nose	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Hay fever	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Sneezing attacks	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

Nose Total:

Mouth / Throat	Frequent, consistent coughing	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Gagging, need to clear throat	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Sore throat, hoarse, loss of voice	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Swollen or discolored tongue, gums, or lips	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

Mouth / Throat Total:

Ears	Itchy ears	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Earaches, ear infections	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Drainage from ear, waxy buildup	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Ringing in ears, hearing loss	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

Ears Total:

Head	Headaches	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Faintness or lightheadedness	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Dizziness	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

Head Total:

Cognitive	Poor memory, recall	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Confusion, poor comprehension	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Poor concentration	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Poor physical coordination	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Difficulty in making decisions	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Stuttering, stammering	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Slurred speech	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	Learning disabilities	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

Cognitive Total:

Grand Total _____

For Practitioner Use Only:

Urinary pH _____

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 _____

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 _____

Overall Score Tabulation

For Practitioner Use Only:

Part 1: Symptoms Grand Total _____ (High >50; moderate 15-49; low <14)

Part 2: XTT Total _____ (High >10; moderate 5-9; low <4)

Part 3: Alkalizing Assessment Total _____ (High ≥1)

Urinary pH _____

Notes:

- Patients with high symptoms but low XTT may be exhibiting reactions that are not related to toxic load. Other mechanisms should be considered, such as inflammation/immune/allergy, gastrointestinal dysfunction, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.
- Recommend non-alkalizing nutrients if patient answers "yes" to any questions in the Alkalizing Assessment.

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.