

Metabolic Detoxification Questionnaire

Part 1: Symptoms

Name _____ Date _____

Rate each of the following symptoms based on how you've been feeling for the: Past 48 hours Past week Past 30 days

Point Scale

0 — Never or almost never have the symptoms	2 — Occasionally have it; effect is severe
1 — Occasionally have it; effect is not severe	3 — Frequently have it; effect is not severe
	4 — Frequently have it; effect is severe

Head

- _____ Headaches
- _____ Faintness
- _____ Dizziness
- _____ Insomnia

Total _____

Eyes

- _____ Watery or itchy eyes
- _____ Swollen, reddened or sticky eyelids
- _____ Bags or dark circles under eyes
- _____ Blurred or tunnel vision (does not include near- or farsightedness)

Total _____

Ears

- _____ Itchy ears
- _____ Earaches, ear infections
- _____ Drainage from ear
- _____ Ringing in ears, hearing loss

Total _____

Nose

- _____ Stuffy nose
- _____ Sinus problems
- _____ Hay fever
- _____ Sneezing attacks
- _____ Excessive mucus formation

Total _____

Mouth/Throat

- _____ Chronic coughing
- _____ Gagging, frequent need to clear throat
- _____ Sore throat, hoarseness, loss of voice
- _____ Swollen or discolored tongue, gums, or lips
- _____ Canker sores

Total _____

Skin

- _____ Acne
- _____ Hives, rashes, dry skin
- _____ Hair loss
- _____ Flushing, hot flashes
- _____ Excessive sweating

Total _____

Heart

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

Total _____

Lungs

- _____ Chest congestion
- _____ Asthma, bronchitis
- _____ Shortness of breath
- _____ Difficulty breathing

Total _____

Digestive Tract

- _____ Nausea, vomiting
- _____ Diarrhea
- _____ Constipation
- _____ Bloating feeling
- _____ Belching, passing gas
- _____ Heartburn
- _____ Intestinal/stomach pain

Total _____

Joints/Muscles

- _____ Pain or aches in joints
- _____ Arthritis
- _____ Stiffness or limitation of movement
- _____ Pain or aches in muscles
- _____ Feeling of weakness or tiredness

Total _____

Weight

- _____ Binge eating/drinking
- _____ Craving certain foods
- _____ Excessive weight
- _____ Compulsive eating
- _____ Water retention
- _____ Underweight

Total _____

Energy/Activity

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

Total _____

Mind

- _____ Poor memory
- _____ Confusion, poor comprehension
- _____ Poor concentration
- _____ Poor physical coordination
- _____ Difficulty in making decisions
- _____ Stuttering or stammering
- _____ Slurred speech
- _____ Learning disabilities

Total _____

Emotions

- _____ Mood swings
- _____ Anxiety, fear, nervousness
- _____ Anger, irritability, aggressiveness
- _____ Depression

Total _____

Other

- _____ Frequent illness
- _____ Frequent or urgent urination
- _____ Genital itch or discharge

Total _____

For Practitioner Use Only:
Urinary pH _____

Grand Total _____

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 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 on 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 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.
- Recommend non-alkalizing nutrients if patient answers "yes" to any questions in the Alkalizing Assessment.