

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	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
	Ringings 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

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 ____ 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

For Practitioner Use Only:

Part 1: Symptoms Grand Total ____ 0 ____ (High >50; moderate 15-49; low <14)

Part 2: XTT Total ____ 0 ____ (High >10; moderate 5-9; low <4)

Part 3: Alkalizing Assessment Total ____ 0 ____ (High ≥1)

Urinary pH ____ 0 ____

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.