Detoxification Questionnaire

Name:_____ Date: _____/____/_____

Please read the following symptoms and rate them based on how you have been feeling over the past 30 days. Fill in the blanks using the appropriate numbers on the key below.

KEY:
0 (or leave blank) = No, never, or almost never occurs
1 = Occasionally occurs, effect is not severe
2 = Occasionally occurs, effect is severe
3 = Frequently occurs, effect is not severe
4 = Frequently occurs, effect is severe

Gastrointestinal
_____ Belching or gas
_____ Heartburn or acid reflux
_____ Bloating or abdominal discomfort shortly after eating
_____ Bad breath (halitosis)
_____ Aggravated by certain foods
_____ Diarrhea, chronic
_____ Undigested food in stool
_____ Constipation
_____ Nausea or vomiting
_____ Fewer than one bowel movement a day
_____ Stools are loose and unformed
_____ **TOTAL**

Liver
_____ Wine makes you sick
_____ Easily intoxicated if drinking alcohol
_____ Hangovers after drinking alcohol
_____ Sensitive to chemicals (perfume, solvents, exhaust)
_____ Sensitive to tobacco smoke
_____ Hemorrhoids or varicose veins
_____ Bothered by aspartame (NutraSweet)
_____ Chronic fatigue or Fibromyalgia
_____ Feeling wired or jittery if drinking coffee
_____ Feet have a strong odor
_____ Sweat has a strong odor
_____ **TOTAL**

Skin
_____ Experience hives, cysts, boils, rashes
_____ Cold sores, fever blisters, or herpes lesions
_____ Dry flaky skin and/or dandruff
_____ Fragile skin, easily chaffed, as in shaving
_____ Acne
_____ Itchy skin / dermatitis
_____ Dull colored skin, yellowish, pale or grayish
_____ Pale complexion
_____ Skin has a sour or unpleasant odor
_____ **TOTAL**

Eyes
_____ Dark circles around the eyes
_____ Puffy eyelids
_____ Bags under the eyes
_____ Bloodshot or reddened eyes
_____ Whites of eyes are yellowed
_____ Inflamed eyelids
_____ Eyes are water and/or itchy
_____ Blurred or tunnel vision
_____ **TOTAL**

Nails
_____ Ridged nails
_____ Splitting nails
_____ White spots on nails
_____ Crumbling nails
_____ **TOTAL**

Ears
_____ Ear infections
_____ Ear drainage or discharge
_____ Itchy ears
_____ Ringing in the ears
_____ **TOTAL**

Nose
_____ Stuffy nose
_____ Airborne allergies
_____ Sinus congestion, "stuffy head", sinus infections
_____ Runny or drippy nose
_____ **TOTAL**

Head
_____ Tension headaches at base of skull
_____ Splitting type headache
_____ Dizziness
_____ Faintness
_____ **TOTAL**

Mouth and Throat

_____ Coated tongue (yellow, grayish-white or thick film)
_____ Swollen tongue
_____ Hoarseness
_____ Difficulty swallowing
_____ Lump in throat
_____ Dry mouth, eyes and / or nose
_____ Gag easily or need to clear throat often
_____ Mouth ulcers or canker sores
_____ **TOTAL**

Heart/Lungs

_____ Asthma
_____ Wheezing or difficulty breathing
_____ Shortness of breath
_____ Chest congestion
_____ Heart races, rapid heartbeat
_____ Fast pulse at rest
_____ Flush or blush easily or face turns red for no reason
_____ Heart skips beats
_____ **TOTAL**

Mental Emotional

_____ Feel 'foggy', thinking seems slow or fuzzy
_____ Bizarre vivid or nightmarish dreams
_____ Depressed
_____ Worried, apprehensive, anxious
_____ Nervous or agitated
_____ Mentally sluggish, reduced initiative
_____ Difficulty concentrating
_____ Mood swings
_____ Coordination is poor
_____ Poor memory
_____ **TOTAL**

Musculoskeletal

_____ Pain or swelling in joints
_____ Muscles become easily fatigued
_____ Muscle aches and pains
_____ Arthritic tendencies
_____ Joints are painful upon waking
_____ Joint pain after mild exertion
_____ Joint pain experienced after eating certain foods
_____ Abdomen tends to hang out
_____ Surface of abdomen is uneven and distended
_____ Use over-the-counter pain medications
_____ **TOTAL**

Metabolism

_____ Pulse speeds after eating
_____ Night sweats
_____ MSG sensitivity
_____ Mood swings associated with periods (PMS)
_____ Breast tenderness associated with cycle
_____ **TOTAL**

Energy Levels

_____ Weakness
_____ Easily fatigued, sleepy during the day
_____ Fatigue is persistent and extreme
_____ Apathetic and lethargic
_____ Tired, in spite of a good night of rest
_____ **TOTAL**

Weight

_____ Crave bread or noodles
_____ Crave certain foods
_____ Retaining water
_____ Excessive weight
_____ **TOTAL**

Kidney

_____ Urine has a strong odor
_____ Pain in mid back region
_____ Urine is frothy
_____ Urinate infrequently
_____ **TOTAL**

Immune System

_____ Frequent infections (bladder, skin, ear, chest, sinus)
_____ Frequent colds or flu
_____ **TOTAL**

Other

_____ Food allergies
_____ Feel worse in moldy or musty place
_____ **TOTAL**

Please add the numbers from each section and write the total in the space provided under that section. Then add all the totals for each section together and put that total in the space below.

GRAND TOTAL _____