

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 watery 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**

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**

Metabolism

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

_____ **TOTAL**

Weight

- _____ Crave bread or noodles
- _____ Crave certain foods
- _____ Retaining water
- _____ Excessive weight

_____ **TOTAL**

Immune System

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

_____ **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**

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**

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**

Kidney

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

_____ **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 _____