

## Detoxification Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Rate each symptom you've experienced during the [ ] Past month [ ] Past week [ ] Past 48 hours

Point Scale:

0 – *Never or almost never* have the symptoms

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*

### MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

<p><b>Head</b></p> <p>___ Headaches</p> <p>___ Faintness</p> <p>___ Dizziness</p> <p>___ Insomnia                      <b>Total</b> _____</p>	<p><b>Digestive Tract</b></p> <p>___ Nausea, vomiting</p> <p>___ Diarrhea</p> <p>___ Constipation</p> <p>___ Bloating feeling</p> <p>___ Belching, passing gas</p> <p>___ Heartburn</p> <p>___ Intestinal/stomach pain                      <b>Total</b> _____</p>
<p><b>Eyes</b></p> <p>___ Watery or itchy eyes</p> <p>___ Swollen, reddened or sticky eyelids</p> <p>___ Bags or dark circles under eyes</p> <p>___ Blurred or tunnel vision                      <b>Total</b> _____</p>	<p><b>Joints/Muscle</b></p> <p>___ Pain or aches in joints</p> <p>___ Arthritis</p> <p>___ Stiffness or limitation of movement</p> <p>___ Feeling weakness or tiredness</p> <p>___ Pain or aches in muscles                      <b>Total</b> _____</p>
<p><b>Ears</b></p> <p>___ Itchy ears</p> <p>___ Ear aches, ear infections</p> <p>___ Drainage from ears</p> <p>___ Ringing in ears, hearing loss                      <b>Total</b> _____</p>	<p><b>Weight</b></p> <p>___ Binge eating/drinking</p> <p>___ Craving certain foods</p> <p>___ Excessive weight</p> <p>___ Water retention</p> <p>___ Underweight</p> <p>___ Compulsive eating                      <b>Total</b> _____</p>
<p><b>Nose</b></p> <p>___ Stuffy nose</p> <p>___ Sinus problems</p> <p>___ Hay fever</p> <p>___ Sneezing attacks</p> <p>___ Excessive mucus formation                      <b>Total</b> _____</p>	<p><b>Energy/Activity</b></p> <p>___ Fatigue, sluggishness</p> <p>___ Apathy, lethargy</p> <p>___ Hyperactivity</p> <p>___ Restlessness                      <b>Total</b> _____</p>
<p><b>Mouth/Throat</b></p> <p>___ Chronic coughing</p> <p>___ Gagging, frequent need to clear throat</p> <p>___ Sore throat, hoarseness, loss of voice</p> <p>___ Swollen or discolored tongue, gums, lips</p> <p>___ Canker sores                      <b>Total</b> _____</p>	<p><b>Mind</b></p> <p>___ Poor memory</p> <p>___ Confusion, poor comprehension</p> <p>___ Difficulty in making decisions</p> <p>___ Stuttering or stammering</p> <p>___ Slurred speech</p> <p>___ Learning disability</p> <p>___ Poor concentration</p> <p>___ Poor physical coordination                      <b>Total</b> _____</p>
<p><b>Skin</b></p> <p>___ Acne</p> <p>___ Hives, rashes, dry skin</p> <p>___ Hair loss</p> <p>___ Flushing, hot flashes</p> <p>___ Excessive sweating                      <b>Total</b> _____</p>	<p><b>Emotions</b></p> <p>___ Mood swings</p> <p>___ Anxiety, fear, nervousness</p> <p>___ Anger, irritability, aggressiveness</p> <p>___ Depression                      <b>Total</b> _____</p>
<p><b>Heart</b></p> <p>___ Chest pain</p> <p>___ Irregular or skipped heartbeat</p> <p>___ Rapid or pounding heartbeat                      <b>Total</b> _____</p>	<p><b>Other</b></p> <p>___ Frequent illness</p> <p>___ Frequent or urgent urination</p> <p>___ Genital itch or discharge                      <b>Total</b> _____</p>
<p><b>Lungs</b></p> <p>___ Chest Congestion</p> <p>___ Asthma, Bronchitis</p> <p>___ Shortness of breath</p> <p>___ Difficulty breathing                      <b>Total</b> _____</p>	<p><b>Grand Total (MSQ):</b> _____</p>

## **Xenobiotic Tolerability Test (XTT)**

1. Are you presently using prescription drugs?

- Yes (1 point). If yes, how many are you currently taking? \_\_\_\_\_ (1 point each)  
 No (0 points)

2. Are you presently taking one or more of the following over-the-counter drugs?

- Antacids (2 points)  Birth control pill or hormone replacement therapy (2 points)  
 Tylenol (2 points)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:

- I experience side effects and the drug is efficacious at lowered doses (3 points)  
 I experience side effects and the drug is efficacious at usual doses (2 points)  
 I experience no side effects and the drug is usually not efficacious (2 points)  
 I experience *no* side effects and the drug is usually efficacious (0 points)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?

- Yes (2 points)  No (0 points)

5. Do you have strong reactions to caffeine or caffeine containing products?

- Yes (1 point)  Don't know (0 points)  
 No (0 points)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?

- Yes (1 point)  No (0 points)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?

- Yes (1 point)  Don't know (0 points)  
 No (0 points)

8. Do you feel ill after you consume even small amounts of alcohol?

- Yes (1 point)  Don't know (0 points)  
 No (0 points)

10. Do you have a personal history of:

- Environmental and/or chemical sensitivities (5 points)  Fibromyalgia (3 points)  
 Chronic fatigue syndrome (5 points)  Parkinson's type symptoms (3 points)  
 Multiple chemical sensitivity (5 points)  Alcohol or chemical dependence (2 points)  
 Asthma (1 point)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?

- Yes (1 point)  No (0 points)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit or salad bar vegetables?

- Yes (1 point)  Don't know (0 points)  
 No (0 points)

**GRAND TOTAL (XTT):** \_\_\_\_\_

### **OVERALL SCORE TABULATION**

MSQ SCORE \_\_\_\_\_ (High >50; moderate 15-49; Low <14)  
XTT SCORE \_\_\_\_\_ (High >10; moderate 5-9; Low <4)