

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	
	Ringing 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 _____