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Advance Biomedical Treatment Center

DETOXIFICATION QUESTIONNAIRE

Patient Name: ______________________________ **Date:** ______________

Rate each of the following symptoms based on your typical health profile for the specified duration:

❒ Past month ❒ Past week ❒ Past 48 hours

Point Scale: **0**—*Never or almost never* 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*

I. Medical Symptoms Questionnaire (MSQ)

HEAD
_______ Headaches
_______ Faintness
_______ Dizziness
_______ Insomnia **TOTAL** _______

EYES
_______ Watery or itchy eyes
_______ Swollen, reddened or sticky eyelids
_______ Bags or dark circles under eyes
_______ Blurred or tunnel vision **TOTAL** _______

EARS
_______ Itchy ears
_______ Earaches, ear infections
_______ Drainage from ear
_______ Ringing in ears, hearing loss **TOTAL** _______

NOSE
_______ Stuffy nose
_______ Sinus problems
_______ Hay fever
_______ Sneezing attacks
_______ Excessive mucus formation **TOTAL** _______

MOUTH/ THROAT
_______ Chronic coughing
_______ Gagging, frequent need to clear throat
_______ Sore throat, hoarseness, loss of voice
_______ Swollen or discolored tongue, gums, lips
_______ Canker sores **TOTAL** _______

SKIN
_______ Acne
_______ Hives, rashes, dry skin
_______ Hair loss
_______ Flushing, hot flashes
_______ Excessive sweating **TOTAL** _______

HEART
_______ Chest pain
_______ Irregular or skipped heartbeat
_______ Rapid or pounding heartbeat **TOTAL** _______

LUNGS
_______ Chest congestion
_______ Asthma, bronchitis
_______ Shortness of breath
_______ Difficulty breathing **TOTAL** _______

DIGESTIVE TRACT
_______ Nausea, vomiting
_______ Diarrhea
_______ Constipation
_______ Bloated feeling
_______ Belching, passing gas
_______ Heartburn
_______ Intestinal/stomach pain **TOTAL** _______

JOINTS/ MUSCLE
_______ Pain or aches in joints
_______ Arthritis
_______ Stiffness or limitation of movement
_______ Feeling of weakness or tiredness
_______ Pain or aches in muscles **TOTAL** _______

WEIGHT
_______ Binge eating/drinking
_______ Craving certain foods
_______ Excessive weight
_______ Water retention
_______ Underweight
_______ Compulsive eating **TOTAL** _______

ENERGY/ ACTIVITY
_______ Fatigue, sluggishness
_______ Apathy, lethargy
_______ Hyperactivity
_______ Restlessness **TOTAL** _______

MIND
_______ Poor memory
_______ Confusion, poor comprehension
_______ Difficulty in making decisions
_______ Stuttering or stammering
_______ Slurred speech
_______ Learning disabilities
_______ Poor concentration
_______ Poor physical coordination **TOTAL** _______

EMOTIONS
_______ Mood swings
_______ Anxiety, fear, nervousness
_______ Anger, irritability, aggressiveness
_______ Depression **TOTAL** _______

OTHER
_______ Frequent illness
_______ Frequent or urgent urination
_______ Genital itch or discharge **TOTAL** _______

GRAND TOTAL **TOTAL** _______

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II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
❒ Yes (1 pt.)
If yes, how many are you currently taking? _____ (1 pt. each)
❒ No (0 pt.)

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 use or within the last 6 months had 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 on 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.)

GRAND TOTAL: ____________

III. Alkalizing Assessment

1. Do you have a history or currently have kidney dysfunction?
❒ Yes ❒ No

2. Have you ever been diagnosed with a condition known as hyperkalemia?
❒ Yes ❒ No

3. Are you currently on diuretics or blood pressure medication?
❒ Yes ❒ No

Note: Prescribe non-alkalizing nutrients if patient answered yes to any part of this section.

For Practitioner Use Only:

OVERALL SCORE TABULATION

See doctor brochure for protocol suggestions.

MSQ SCORE __________ (High >50; moderate 15-49: Low <14)
XTT SCORE __________ (High >10; moderate 5-9: Low <4)
URINARY pH __________

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neuro-transmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.