

**Detoxification Questionnaire**

**Patient Name** \_\_\_\_\_

**Date:** \_\_\_\_\_

Rate each of the following symptoms based on your typical health profile for the **past month**.

**Point Scale: 0 to 5;** 0 (Never have the symptom) to 5 (Very frequently have the symptom)

**HEAD** \_\_\_\_\_ Headaches  
 \_\_\_\_\_ Dizziness/ faintness  
**TOTAL** \_\_\_\_\_

**EYES** \_\_\_\_\_ Bags or dark circles under eyes  
 \_\_\_\_\_ Watery or itchy eyes  
 \_\_\_\_\_ Blurred or changed vision  
**TOTAL** \_\_\_\_\_

**EARS** \_\_\_\_\_ Itchy ears  
 \_\_\_\_\_ Ear aches/ infections  
 \_\_\_\_\_ Ringing in ears  
 \_\_\_\_\_ Hearing reduction  
**TOTAL** \_\_\_\_\_

**NOSE** \_\_\_\_\_ Frequent colds  
 \_\_\_\_\_ Stuffy nose/ congestion  
 \_\_\_\_\_ High mucus formation  
 \_\_\_\_\_ Sinus problems  
 \_\_\_\_\_ Hay fever  
**TOTAL** \_\_\_\_\_

**MOUTH/  
THROAT** \_\_\_\_\_ Chronic coughing  
 \_\_\_\_\_ Frequent sore throat  
 \_\_\_\_\_ Hoarseness  
 \_\_\_\_\_ Dental problems  
 \_\_\_\_\_ Canker sores  
**TOTAL** \_\_\_\_\_

**SKIN** \_\_\_\_\_ Itchiness  
 \_\_\_\_\_ Acne/ eczema/ psoriasis  
 \_\_\_\_\_ Hives/ rashes/ dry skin  
 \_\_\_\_\_ Hair loss  
 \_\_\_\_\_ Flushing/ hot flashes  
**TOTAL** \_\_\_\_\_

**HEART** \_\_\_\_\_ Irregular or rapid heartbeat  
 \_\_\_\_\_ High blood pressure  
 \_\_\_\_\_ Chest pain  
 \_\_\_\_\_ Heart disease  
 \_\_\_\_\_ Ankle swelling  
**TOTAL** \_\_\_\_\_

**LUNGS** \_\_\_\_\_ Asthma/ bronchitis  
 \_\_\_\_\_ Shortness of breath  
**TOTAL** \_\_\_\_\_

**DIGESTIVE  
TRACT** \_\_\_\_\_ Bloating  
 \_\_\_\_\_ Burping  
 \_\_\_\_\_ Gas/ Flatulence  
 \_\_\_\_\_ Diarrhea  
 \_\_\_\_\_ Constipation/ straining  
 \_\_\_\_\_ Heartburn/ indigestion  
 \_\_\_\_\_ Nausea/ vomiting  
 \_\_\_\_\_ Blood or mucous in stool  
 \_\_\_\_\_ Intestinal/ stomach pain  
**TOTAL** \_\_\_\_\_

**JOINTS/  
MUSCLE** \_\_\_\_\_ Joint pain/ stiffness  
 \_\_\_\_\_ Muscle pain/ stiffness  
 \_\_\_\_\_ Muscle spasms/ cramps  
 \_\_\_\_\_ Limited movement  
 \_\_\_\_\_ Numbness/ tingling  
**TOTAL** \_\_\_\_\_

**EMOTIONS** \_\_\_\_\_ Mood swings  
 \_\_\_\_\_ Anxiety/ nervousness  
 \_\_\_\_\_ Anger/ irritability  
 \_\_\_\_\_ Depression  
**TOTAL** \_\_\_\_\_

**OTHER** \_\_\_\_\_ Fatigue  
 \_\_\_\_\_ High stress  
 \_\_\_\_\_ Sugar cravings  
 \_\_\_\_\_ Poor concentration  
 \_\_\_\_\_ Poor memory  
 \_\_\_\_\_ Weight gain  
 \_\_\_\_\_ Poor sleep/ insomnia  
 \_\_\_\_\_ Appetite change  
 \_\_\_\_\_ Low libido  
 \_\_\_\_\_ Change in hair/ nails  
 \_\_\_\_\_ Feel cold often  
 \_\_\_\_\_ Easy bruising  
**TOTAL** \_\_\_\_\_

**GRAND TOTAL:** \_\_\_\_\_

**Scoring Test Results**

- If you scored under 20 ... Your health is balanced. Detoxification programs are a preventative tool for you.
- If you scored 21 – 50 ... Your health is needing attention. Detoxification programs will help you feel better now.
- If you scored 51 – 100... Your health is challenged. Detoxification is recommended over the next 6-8 weeks.
- If you scored > 100 ... Your health is needing prolonged supportive intervention to reestablish proper function.

## Lifestyle Information:

**STRESS**                      Yes    No                      *How Much?* \_\_\_\_\_

**SMOKING**                      Yes    No                      *How Much?* \_\_\_\_\_

**ALCOHOL**                      Yes    No                      *How Much?* \_\_\_\_\_

**RECREATIONAL DRUGS**    Yes    No                      *How Often?* \_\_\_\_\_

**EXERCISE**                      Yes    No                      *Frequency* \_\_\_\_\_

*Type* \_\_\_\_\_

*Duration* \_\_\_\_\_

**NUTRITION**                      Water                      *How Much/Day?* \_\_\_\_\_

Coffee                      *How Much/Day?* \_\_\_\_\_

Tea                      *How Much/Day?* \_\_\_\_\_

Juice                      *How Much/Day?* \_\_\_\_\_

Pop                      *How Much/Day?* \_\_\_\_\_

Milk                      *How Much/Day?* \_\_\_\_\_

Cheese/Yogurt                      *How Often?* \_\_\_\_\_

Bread                      *How Much/Day?* \_\_\_\_\_

Sugar, Treats                      *How Often?* \_\_\_\_\_

*What Type* \_\_\_\_\_

Artificial Sweeteners                      *How Often?* \_\_\_\_\_

**WEIGHT**                      Today                      \_\_\_\_\_

1 Year Ago                      \_\_\_\_\_

Goal                      \_\_\_\_\_

## TYPICAL DAILY MEALS:

Morning

Afternoon

Evening

Snacks