# Metabolic Detoxification Questionnaire

## Part 1: Symptoms

Name: Date:

Rate each of the following symptoms based on the last week using the point scale below:

1. Never or rarely have the symptom 3 Frequently have it, effect is not severe
2. Occasionally have it, effect is not severe 4 Frequently have it, effect is severe 2 Occasionally have it, effect is severe

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Digestive Tract | Nausea, vomiting | 0 | | 1 | 2 | 3 | 4 | Respiratory | | Chest congestion |  | 0 | 1 | 2 | 3 | 4 |
|  | Diarrhea | 0 | | 1 | 2 | 3 | 4 |  | | Asthma, bronchitis |  | 0 | 1 | 2 | 3 | 4 |
|  | Constipation | 0 | | 1 | 2 | 3 | 4 |  | | Shortness of breath |  | 0 | 1 | 2 | 3 | 4 |
|  | Bloated feeling | 0 | | 1 | 2 | 3 | 4 |  | | Difficulty breathing |  | 0 | 1 | 2 | 3 | 4 |
|  | Heartburn | 0 | | 1 | 2 | 3 | 4 |  | |  | Respiratory Total: |  |  | 0 |  |  |
|  | Intestinal, stomach pain |  | 0 | 1 | 2 | 3 | 4 |  | Eyes | Watery or itchy ]yes | | 0 | 1 | 2 | 3 | 4 |
|  |  | Digestive Total: |  |  | 0 |  |  |  |  | Swollen, red$ or sticky eyelids | | 0 | 1 | 2 | 3 | 4 |
| Joints / Muscles | Pain or aches in joints |  | 0 | 1 | 2 | 3 | 4 |  |  | Bags or dark circles under eyes | | 0 | 1 | 2 | 3 | 4 |
|  | Arthritis, joint swelling |  | 0 | 1 | 2 | 3 | 4 |  |  | Blurred or restricted vision | | 0 | 1 | 2 | 3 | 4 |
| Stiff or limitation of movement | | | 0 | 1 | 2 | 3 | 4 | | Eyes Total: | | | 0 | | | | |
| Pain or aches in muscles | | | 0 | 1 | 2 | 3 | 4 | Nose | | Stuffy nose | | 0 | 1 | 2 | 3 | 4 |
| Feeling of weakness or tired | | | 0 | 1 | 2 | 3 | 4 |  | | Sinus problems or dripping nose | | 0 | 1 | 2 | 3 | 4 |
| Joints / Muscles Total: 0 Hay fever 0 | | | | | | | | | | | | | 1 | 2 | 3 | 4 |
| Emotional | Mood swings | 0 | | 1 | 2 | 3 | 4 | Sneezing attacks | | | 0 | | 1 | 2 | 3 | 4 |
|  | Anxiety, fear, nervousness | 0 | | 1 | 2 | 3 | 4 | Excessive mucus | | | 0 | | 1 | 2 | 3 | 4 |

Anger, irritability, aggression



0



1



2



3



4

Nose Total: 0

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Depression 0 | 1 | 2 | 3 | 4 |  | Mouth / Throat | Frequent, consistent coughing | 0 | 1 | 2 | 3 | 4 |
| Emotional Total: |  | 0 |  |  |  |  | Gagging, need to clear throat | 0 | 1 | 2 | 3 | 4 |
| Weight / Food Binge eating, drinking 0 | 1 | 2 | 3 | 4 |  |  | Sore throat, hoarse, loss of voice | 0 | 1 | 2 | 3 | 4 |
| Craving certain foods 0 | 1 | 2 | 3 | 4 |  |  | Swollen or discolored tongue, gums, or lips | 0 | 1 | 2 | 3 | 4 |
| Excessive weight 0 | 1 | 2 | 3 | 4 |  |  | Canker sores, other mouth sores | 0 | 1 | 2 | 3 | 4 |

Compulsive eating, food addictions



0



1



2



3



4

Mouth / Throat Total: 0

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Water retention 0 | 1 | 2 | 3 | 4 |  | Ears | Itchy ears | 0 | 1 | 2 | 3 | 4 |
| Underweight 0 | 1 | 2 | 3 | 4 |  |  | Earaches, ear infections | 0 | 1 | 2 | 3 | 4 |
| Weight / Food Total: |  | 0 |  |  |  |  | Drainage from ear, waxy buildup | 0 | 1 | 2 | 3 | 4 |
| Energy / Sleep Fatigue, sluggishness 0 | 1 | 2 | 3 | 4 |  |  | Ringing in ears, hearing loss | 0 | 1 | 2 | 3 | 4 |

Apathy, lethargy



0



1



2



3



4

Ears Total: 0

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Hyperactivity | | 0 | 1 | 2 | 3 | 4 | | Head | Headaches | 0 | 1 | 2 | 3 | 4 |
| Restlessness, achiness | | 0 | 1 | 2 | 3 | 4 | |  | Faintness or lightheadedness | 0 | 1 | 2 | 3 | 4 |
| Sleep disturbances | | 0 | 1 | 2 | 3 | 4 | |  | Dizziness | 0 | 1 | 2 | 3 | 4 |
| Energy / Sleep Total: 0 Head Total: 0 | | | | | | | | | | | | | | |
| Skin | Acne | 0 | 1 | 2 | 3 | 4 |  | Cognitive | Poor memory, recall | 0 | 1 | 2 | 3 | 4 |
|  | Hives, rashes, dry skin, redness | 0 | 1 | 2 | 3 | 4 |  |  | Confusion, poor comprehension | 0 | 1 | 2 | 3 | 4 |
|  | Hair loss | 0 | 1 | 2 | 3 | 4 |  |  | Poor concentration | 0 | 1 | 2 | 3 | 4 |
|  | Flushing, hot flashes | 0 | 1 | 2 | 3 | 4 |  |  | Poor physical coordination | 0 | 1 | 2 | 3 | 4 |
|  | Excessive sweating | 0 | 1 | 2 | 3 | 4 |  |  | Difficulty in making decisions | 0 | 1 | 2 | 3 | 4 |

Skin Total: 0

Stuttering, stammering

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Heart | Irregular or skipped heartbeat | 0 | | 1 | 2 | 3 | 4 | Slurred speech |  | 0 | 1 | 2 | 3 | 4 |
|  | Rapid or pounding heartbeat | 0 | | 1 | 2 | 3 | 4 | Learning disabilities |  | 0 | 1 | 2 | 3 | 4 |
|  | Chest pain | 0 | | 1 | 2 | 3 | 4 |  | Cognitive Total: |  |  | 0 |  |  |
|  |  | Heart Total: |  |  | 0 |  |  |  | | | | | | |
| Other | Frequent illness |  | 0 | 1 | 2 | 3 | 4 |  | | | | | | |
|  | Frequent or urgent urination |  | 0 | 1 | 2 | 3 | 4 | 0 | | | | | | |
|  | Genital itch or discharge |  | 0 | 1 | 2 | 3 | 4 | Grand Total | | | | | | |
|  |  | Other Total: |  |  | 0 |  |  |  | | | | | | |

For 3UDFWiWiRQHU Use Only:



0



1



2



3



4

Urinary pH



Metabolic Detoxification Questionnaire

Part 2: Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?

 Yes (1 pt.)  No (0 pt.)

If yes, how many are you currently taking? (1 pt. each)

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

 Cimetidine (2 pts.)  Acetaminophen (2 pts.)  Estradiol (2 pts.)

1. 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.)

1. Do you currently (within the last 6 months) or have you regularly used tobacco products?

 Yes (2 pts.)  No (0 pt.)

1. Do you have strong negative reactions to caffeine or caffeine-containing products?

 Yes (1 pt.)  No (0 pt.)  Don’t know (0 pt.)

1. Do you commonly experience “brain fog,” fatigue, or drowsiness?

 Yes (1 pt.)  No (0 pt.)

1. Do you develop symptoms with exposure to fragrances, exhaust fumes, or strong odors?

 Yes (1 pt.)  No (0 pt.)  Don’t know (0 pt.)

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

 Yes (1 pt.)  No (0 pt.)  Don’t know (0 pt.)

1. 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.)

1. 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.)

1. 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.)

Total

0

Part 3: Alkalizing Assessment

1. Do you have a history of or currently have kidney dysfunction?

 Yes (1 pt.)  No (0 pt.)

1. Have you ever been diagnosed with hyperkalemia?

Yes (1 pt.) No (0 pt.)

1. Are you currently taking diuretics or blood pressure medication?

Yes (1 pt.) No (0 pt.)

Total

0

Overall Score Tabulation

For Practitioner Use Only:

Part 1: Symptoms Grand Total 0

(High >50; moderate 15-49; low <14)

Part 2: XTT Total 0 (High >10; moderate 5-9; low <4)

Part 3: Alkalizing Assessment Total 0 (High 1)

Urinary pH 0

Notes:

* Patients with high symptoms but low XTT may be exhibiting reactions that are not related to toxic load. Other mechanisms should be considered, such as inflammation/ immune/allergy, gastrointestinal \qk^mf[ligf, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.
* Recommend non-alkalizing nutrients if patient answers “yes” to any questions in the Alkalizing Assessment.

Disclaimer: This questionnaire is for informational purposes only. It is not meant to diagnose or treat any condition or illness. All medical symptoms should be addressed by a qualified medical professional.

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