

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	
	_____ Bloating 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 _____