# QUESTIONNAIRE

## SIGNS OF POOR DETOXIFICATION

Read the following questions and rate them based on how you have been feeling in the past 30 days. Add the numbers from each section and enter the total in the spaces provided.




Scoring
0 (or leave blank) = No, or never, or almost never occurs
1 = Occasionally occurs, effect is not severe
2 = Occasionally occurs, effect is severe
3 = Frequently occurs, effect is not severe

### LIVER

_____ Wine makes you sick
_____ Easily intoxicated if drinking alcohol
_____ Hangovers after drinking alcohol
_____ Sensitive to chemicals (perfume, solvents, exhaust)
_____ Sensitive to tobacco smoke
_____ Hemorrhoids or varicose veins
_____ Bothered by aspartame (NutraSweet)
_____ Chronic Fatigue or Fibromyalgia
_____ Feeling wired or jittery if drinking coffee
_____ Feet have a strong odor
_____ Sweat has a strong odor

_____ **TOTAL**

### GASTROINTESTINAL

_____ Belching or gas
_____ Heartburn or acid reflux
_____ Bloating or abdominal discomfort shortly after eating
_____ Bad breath (halitosis)
_____ Aggravated by certain foods
_____ Diarrhea, chronic
_____ Undigested food in stool
_____ Constipation
_____ Nausea or vomiting
_____ Fewer than one bowel movement a day
_____ Stools are loose and unformed

_____ **TOTAL**

### EARS

_____ Ear infections
_____ Ear drainage or discharge
_____ Itchy ears
_____ Ringing in the ears

_____ **TOTAL**

### EYES

_____ Dark circles around the eyes
_____ Puffy eyelids
_____ Bags under the eyes
_____ Bloodshot or reddened eyes
_____ Whites of eyes are yellowed
_____ Inflamed eyelids
_____ Eyes are water and/or itchy
_____ Blurred or tunnel vision

_____ **TOTAL**

### MENTAL EMOTIONAL

_____ Feel spacey, thinking seems slow or fuzzy
_____ Bizarre vivid or nightmarish dreams
_____ Depressed Worried, apprehensive, anxious
_____ Nervous or agitated
_____ Mentally sluggish, reduced initiative
_____ Difficulty concentrating
_____ Mood swings
_____ Coordination is poor
_____ Poor memory

_____ **TOTAL**

### HEAD

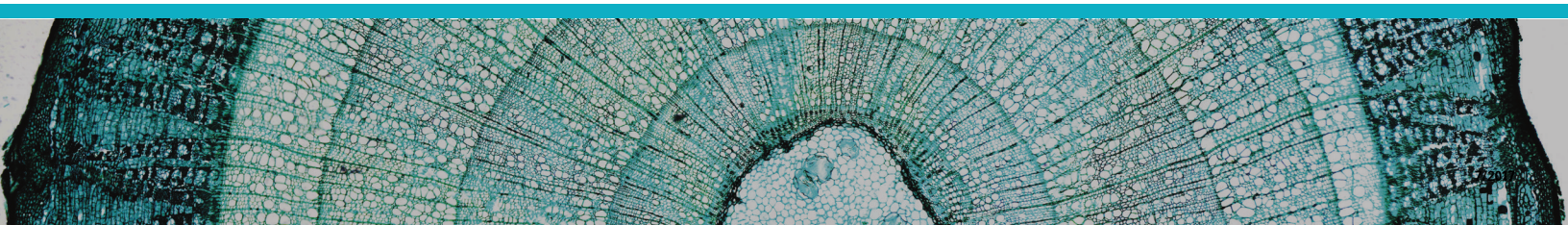
_____ Tension headaches at base of skull
_____ Splitting type headache
_____ Dizziness
_____ Faintness

_____ **TOTAL**

### SKIN

_____ Experience hives, cysts, boils, rashes
_____ Cold sores, fever blisters, or herpes lesions
_____ Dry flaky skin and/or dandruff
_____ Fragile skin, easily chaffed, as in shaving
_____ Acne Itchy skin / dermatitis

**Disclaimer:** This questionnaire is not intended to be used to diagnose any disease or as a basis for prescribing for any disease. It is solely for clinician insight and patient self-knowledge.



## SKIN CONTINUED

_____ Dull colored skin, yellowish, pale or grayish
_____ Pale complexion
_____ Skin has a sour or unpleasant odor

_____ **TOTAL**

## NOSE

_____ Stuffy nose
_____ Airborne allergies
_____ Sinus congestion, “stuffy head”, sinus infections
_____ Runny or drippy nose
_____ Ulcers
_____ Clinkers (crusty deposits in nose)

_____ **TOTAL**

## NAILS

_____ Ridged nails
_____ Splitting nails
_____ White spots on nails
_____ Crumbling nails
_____ Lack of ‘moons’ (poor peripheral circulation)

_____ **TOTAL**

## MOUTH & THROAT

_____ Coated tongue (yellow, grayish-white or thick film)
_____ Swollen tongue
_____ Hoarseness
_____ Difficulty swallowing
_____ Lump in throat
_____ Dry mouth, eyes and / or nose
_____ Gag easily or need to clear throat often
_____ Mouth ulcers or canker sores

_____ **TOTAL**

## MUSCULOSKELETAL

_____ Pain or swelling in joints
_____ Muscles become easily fatigued
_____ Muscle aches and pains
_____ Arthritic tendencies
_____ Joints are painful upon waking
_____ Joint pain after mild exertion
_____ Joint pain after eating certain foods
_____ Abdomen tends to hang out
_____ Surface of abdomen is uneven and distended
_____ Use over-the-counter pain medications

_____ **TOTAL**

## METABOLISM

_____ Pulse speeds after eating
_____ Night sweats
_____ MSG sensitivity
_____ Mood swings associated with periods (PMS)
_____ Breast tenderness associated with cycle

_____ **TOTAL**

## HEART/LUNGS

_____ Asthma Wheezing or difficulty breathing
_____ Shortness of breath
_____ Chest congestion
_____ Heart races, rapid heartbeat
_____ Fast pulse at rest
_____ Flush or blush easily
_____ Heart skips beats

_____ **TOTAL**

## ENERGY CELLULAR MITOCHONDRIA ABILITY TO GENERATE ATP

_____ Weakness
_____ Easily fatigued, sleepy during the day
_____ Fatigue is persistent and extreme
_____ Apathetic and lethargic
_____ Tired, even after a good nights rest

_____ **TOTAL**

## KIDNEY

_____ Urine has a strong odor
_____ Pain in mid back region
_____ Urine is frothy
_____ Urinate infrequently

_____ **TOTAL**

## WEIGHT

_____ Crave bread or noodles
_____ Crave certain foods
_____ Bloating, Retain water
_____ Excessive weight

_____ **TOTAL**

## IMMUNE SYSTEM

_____ Frequent infections (bladder, skin, ear, chest, sinus)
_____ Frequent colds or flu
_____ Auto-immune diseases (hyperactive immunity)
_____ History of vaccinations (toxic mercury, stimulation by squalene)
_____ History of antibiotics
_____ Food allergies
_____ Feel worse in moldy or musty places

_____ **TOTAL**

## ADD ALL TOTALS FOR EACH SECTION

_____ **GRAND TOTAL**

## HOW TO INTERPRET YOUR SCORE:

15 or less = Excellent
16-30 = Good
31-40 = Marginal need to start detox
51 or more = Very Poor, imperative to detox

**Disclaimer:** This questionnaire is not intended to be used to diagnose any disease or as a basis for prescribing for any disease. It is solely for clinician insight and patient self-knowledge.

