

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Sex \_\_\_\_\_ Number of Children \_\_\_\_\_

Marital Status:  Single  Partner  Married  Separated  Divorced  Widow(er)

Are you recovering from a cold or flu? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Reason for office visit \_\_\_\_\_ Date began \_\_\_\_\_

List current health problems for which you are being treated: \_\_\_\_\_

What types of therapies have you tried for these problem(s) or to improve your health overall:

- Diet modification  Fasting  Vitamins/minerals  Herbs  Homeopathy  Chiropractic  Acupuncture  Conventional drugs  Other \_\_\_\_\_

Do you experience any of these general symptoms on a regular basis?

- Debilitating fatigue  Shortness of breath  Insomnia  Constipation  Chronic pain/inflammation  Depression  Panic attacks  Nausea  Fecal incontinence  Bleeding  Disinterest in sex  Headaches  Vomiting  Urinary incontinence  Discharge  Disinterest in eating  Dizziness  Diarrhea  Low grade fever  Itching/rash

Current medications (prescription or over-the-counter): \_\_\_\_\_

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): \_\_\_\_\_

Outcome: \_\_\_\_\_

Major hospitalization, surgeries, injuries. Please list all procedures, complications (if any), and dates:

Table with 3 columns: Year, Surgery, illness, or injury, Outcome

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, residence or finances): \_\_\_\_\_

Do you consider yourself:  Underweight  Overweight  Healthy weight Your weight today: \_\_\_\_\_

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? \_\_\_\_\_

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) and/or life threatening activities (e.g., firefighter, police officer, etc.)? \_\_\_\_\_

What are your current health goals: \_\_\_\_\_

## Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other \_\_\_\_\_

## Medical (Men)

- Benign prostatic hyperplasia
- Prostate cancer
- Decreased sex drive

- Infertility
- Sexually transmitted disease
- Other \_\_\_\_\_

## Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other \_\_\_\_\_
- Date of last GYN exam \_\_\_\_\_
- Mammogram + -
- PAP + -
- Form of birth control \_\_\_\_\_
- # of children \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- C-section \_\_\_\_\_
- Age of first period \_\_\_\_\_
- Date of last menstrual cycle \_\_\_\_\_
- Length of cycle \_\_\_\_\_ days
- Interval of time between cycles \_\_\_\_\_ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) \_\_\_\_\_
- Surgical menopause
- Menopause

## Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other \_\_\_\_\_

## Health Habits

- Tobacco:
  - Cigarettes: # /day \_\_\_\_\_
  - Cigars: # /day \_\_\_\_\_
- Alcohol:
  - Wine: # glasses/d or wk \_\_\_\_\_
  - Liquor: # ounces/d or wk \_\_\_\_\_
  - Beer: # glasses/d or wk \_\_\_\_\_
- Caffeine:
  - Coffee: # 6 oz cups/d \_\_\_\_\_
  - Tea: # 6 oz cups/d \_\_\_\_\_
  - Soda w/caffeine: # cans/d \_\_\_\_\_
  - Other sources \_\_\_\_\_
- Water: # glasses/d \_\_\_\_\_

## Exercise

- 5-7 days/wk
- 3-4 days/wk
- 1-2 days/wk
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk: #days/wk \_\_\_\_\_
- Run, jog, other aerobic - #days/wk \_\_\_\_\_

- Weight lift: #days/wk \_\_\_\_\_
- Stretch: #days/wk \_\_\_\_\_
- Other \_\_\_\_\_

## Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction

## Specific food restrictions:

- dairy  wheat  eggs
- soy  corn  all gluten
- Other \_\_\_\_\_

## Food Frequency

- Number of servings per day: \_\_\_\_\_
- Fruits (citrus, melons, etc.) \_\_\_\_\_
- Dark green or deep yellow/orange vegetables \_\_\_\_\_
- Grains (unprocessed) \_\_\_\_\_
- Beans, peas, legumes \_\_\_\_\_
- Dairy, eggs \_\_\_\_\_
- Meat, poultry, fish \_\_\_\_\_

## Eating Habits

- Skip meals (which ones) \_\_\_\_\_
- One meal/day
- Two meals/day
- Three meals/day
- Graze (small frequent meals)
- Generally eat on the run
- Eat constantly whether hungry or not

## Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening primrose/GLA
- Calcium, source \_\_\_\_\_
- Magnesium
- Zinc
- Minerals (describe) \_\_\_\_\_
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol)
- Herbs
- Homeopathy
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other \_\_\_\_\_

## I Would Like to:

### Energy, Vitality

- Feel more vital
- Have more energy
- Have more endurance
- Be less tired after lunch
- Sleep better
- Be free of pain
- Get less colds and flu
- Get rid of allergies
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.
- Stop using laxatives and stool softeners
- Improve sex drive

### Body Composition

- Lose weight
- Burn more body fat
- Be stronger
- Have better muscle tone
- Be more flexible

### Stress: Mental and Emotional

- Learn how to reduce stress
- Think more clearly and be more focused
- Improve memory
- Be less depressed
- Be less moody
- Be less indecisive
- Feel more motivated

### Life Enrichment

- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a "treating-illness" orientation to creating a wellness lifestyle

# Metabolic Detoxification Questionnaire

## Part 1: Symptoms

Name \_\_\_\_\_ Date \_\_\_\_\_

Rate each of the following symptoms based on how you've been feeling for the:  Past 48 hours  Past week  Past 30 days

**Point Scale**

0 — Never or almost never have the symptoms	2 — Occasionally have it; effect is severe
1 — Occasionally have it; effect is not severe	3 — Frequently have it; effect is not severe
	4 — Frequently have it; effect is severe

**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 (does not include near- or farsightedness)

**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, or lips

\_\_\_\_\_ Canker sores

**Total** \_\_\_\_\_

**Skin**

\_\_\_\_\_ Acne

\_\_\_\_\_ Hives, rashes, dry skin

\_\_\_\_\_ Hair loss

\_\_\_\_\_ Flushing, hot flashes

\_\_\_\_\_ Excessive sweating

**Total** \_\_\_\_\_

**Heart**

\_\_\_\_\_ Irregular or skipped heartbeat

\_\_\_\_\_ Rapid or pounding heartbeat

\_\_\_\_\_ Chest pain

**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/Muscles**

\_\_\_\_\_ Pain or aches in joints

\_\_\_\_\_ Arthritis

\_\_\_\_\_ Stiffness or limitation of movement

\_\_\_\_\_ Pain or aches in muscles

\_\_\_\_\_ Feeling of weakness or tiredness

**Total** \_\_\_\_\_

**Weight**

\_\_\_\_\_ Binge eating/drinking

\_\_\_\_\_ Craving certain foods

\_\_\_\_\_ Excessive weight

\_\_\_\_\_ Compulsive eating

\_\_\_\_\_ Water retention

\_\_\_\_\_ Underweight

**Total** \_\_\_\_\_

**Energy/Activity**

\_\_\_\_\_ Fatigue, sluggishness

\_\_\_\_\_ Apathy, lethargy

\_\_\_\_\_ Hyperactivity

\_\_\_\_\_ Restlessness

**Total** \_\_\_\_\_

**Mind**

\_\_\_\_\_ Poor memory

\_\_\_\_\_ Confusion, poor comprehension

\_\_\_\_\_ Poor concentration

\_\_\_\_\_ Poor physical coordination

\_\_\_\_\_ Difficulty in making decisions

\_\_\_\_\_ Stuttering or stammering

\_\_\_\_\_ Slurred speech

\_\_\_\_\_ Learning disabilities

**Total** \_\_\_\_\_

**Emotions**

\_\_\_\_\_ Mood swings

\_\_\_\_\_ Anxiety, fear, nervousness

\_\_\_\_\_ Anger, irritability, aggressiveness

\_\_\_\_\_ Depression

**Total** \_\_\_\_\_

**Other**

\_\_\_\_\_ Frequent illness

\_\_\_\_\_ Frequent or urgent urination

\_\_\_\_\_ Genital itch or discharge

**Total** \_\_\_\_\_

For Practitioner Use Only:  
Urinary pH \_\_\_\_\_

**Grand Total** \_\_\_\_\_

# 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)

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 within the last 6 months have 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.)

Total \_\_\_\_\_

## Part 3: Alkalizing Assessment

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

Yes (1 pt.)     No (0 pt.)

2. Have you ever been diagnosed with hyperkalemia?

Yes (1 pt.)     No (0 pt.)

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

Yes (1 pt.)     No (0 pt.)

Total \_\_\_\_\_

## Overall Score Tabulation

For Practitioner Use Only:

Part 1: Symptoms Grand Total \_\_\_\_\_ (High >50; moderate 15-49; low <14)

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

Part 3: Alkalizing Assessment Total \_\_\_\_\_ (High ≥1)

Urinary pH \_\_\_\_\_

Notes:

- Patients with high Symptoms 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 dysfunction, 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.