DETOX & SCREENING QUESTIONNAIRE

NAME:

DATE: / /

What is your main health concern? _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

GENERAL

Have you travelled outside of Australia in the last 6-12 months? If yes, where? _____

History of antibiotic use? _____

Dental history ☐ Silver mercury fillings ☐ Root canal implants ☐ Gingivitis ☐ Bleeding gums

How many alcoholic drinks do you have in a week? ☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10

Do you currently smoke? ☐ No ☐ Yes, how many per day & years? _____

Caffeine intake - cups of tea/coffee per day? ☐ 1 ☐ 2-4 ☐ >4

Do you use recreational drugs? Type: _____

Are you sensitive to caffeinated drinks? ☐ No ☐ Yes

Do you have food reactions or sensitivities? ☐ No ☐ Yes, please describe: _____

_____

Do you adversely react to:
☐ Cheese ☐ Chocolate ☐ Red wine ☐ Caffeine ☐ Sulphite-containing food (eg. wine, dried fruit)
☐ Onions ☐ Garlic ☐ Alcohol ☐ Bananas ☐ Preservatives (eg. Sodium benzoates)
☐ Citrus foods ☐ Artificial sweetener ☐ Monosodium glutamate (MSG) ☐ Other: _____

ENVIRONMENTAL FACTORS

Which of the following strongly affect you?
☐ Perfume/fragrances ☐ Cigarette smoke ☐ Car exhaust fumes ☐ Other: _____

Are you exposed to? ☐ Mould ☐ Electromagnetic radiation (EMFs) ☐ Chemicals

Do you, or have you, lived or worked in a damp or mouldy environment? ☐ No ☐ Yes

Do you have a history of significant exposure to harmful chemicals?
☐ Insecticides ☐ Herbicides ☐ Pesticides ☐ Heavy metals ☐ Organic solvents ☐ Other: _____

What chemicals do you use to clean your house? ☐ Bleach ☐ Antibacterial wipes ☐ Antiseptics ☐ Disinfectants

Do you dry clean your clothes frequently? ☐ No ☐ Yes

Where do you live? ☐ Suburbs ☐ Country ☐ Near power lines ☐ On or near a main road ☐ On a train line
☐ Inner city ☐ Industrial area ☐ Under a flight path ☐ Near a mobile phone tower

What is your profession? _____

Rate each of the following symptoms from 0-4 *(see below)* relating to the last 7 days.
This questionnaire helps identify symptoms that may indicate the underlying causes of illness and helps you track your progress over time. If this is a follow-up questionnaire, please record the symptoms for the last 30 days.

0	1	2	3	4
Never	Experience occassionally, but not severe	Experience occassionally, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe

DIGESTIVE TRACT	SCORE
Nausea and vomiting	
Diarrhoea	
Constipation	
Bloated feeling	
Belching or passing gas	
Heartburn	
Intestinal/stomach pain	
TOTAL	0

EARS	
Itchy ears	
Earaches, ear infections	
Ringing in the ears, hearing loss	
TOTAL	0

EMOTIONS	
Mood swings	
Anxiety, fear, nervous	
Anger, irritability or aggression	
Depression	
TOTAL	0

ENERGY/ACTIVITY	
Fatigue	
Apathy	
Hyperactivity	
Restlessness	
TOTAL	0

EYES	
Itchy or watery	
Bags or dark circles under eyes	
Swollen or red eyelids	
Blurred vision	
TOTAL	0

HEAD	
Headaches	
Faintness	
Dizziness	
Insomnia	
TOTAL	0

JOINT/MUSCLES	SCORE
Arthritis	
Pain or aches in joints	
Pain or aches in muscles	
Stiffness or limitation of movement	
Feeling of weakness or fatigue	
TOTAL	0

LUNGS	
Asthma, bronchitis	
Shortness of breath	
Difficulty breathing	
Mucous congestion	
TOTAL	0

MIND	
Poor memory	
Brain fog, poor concentration	
Confusion, poor comprehension	
Poor physical coordination	
Difficulty making decisions	
Stuttering and stammering	
Slurred speech	
Learning disabilities	
TOTAL	0

MOUTH/THROAT	
Chronic coughing	
Gagging, frequent need to clear throat	
Sore throat, hoarseness of voice, loss of voice	
Swollen/discoloured tongue, gums, lips	
TOTAL	0

HEART	
Irregular heartbeat	
Rapid heartbeat	
Chest pain	
TOTAL	0

NOSE	SCORE
Stuffy nose	
Sinus problems	
Hay fever	
Sneezing attacks	
Excessive mucous formation	
TOTAL	0

SKIN	
Acne	
Hives, rash, dry skin	
Hair loss	
Flushing or hot flushes	
Excessive sweating	
TOTAL	0

WEIGHT	
Binge eating/drinking	
Craving foods	
Excessive weight gain	
Acne	
Compulsive eating	
Water retention	
Underweight	
TOTAL	0

OTHER	
Frequent illness	
Frequent or urgent urination	
Genital itch or discharge	
TOTAL	0

OVERALL SCORE	=	0

KEY

Add individual scores and total each group. Add each sections total and give an overall score.

Optimal: <10
Mild Toxicity: 10-50
Moderate Toxicity: 50-100
Severe Toxicity: >100

Return this questionnaire to your practitioner at your next appointment.