

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

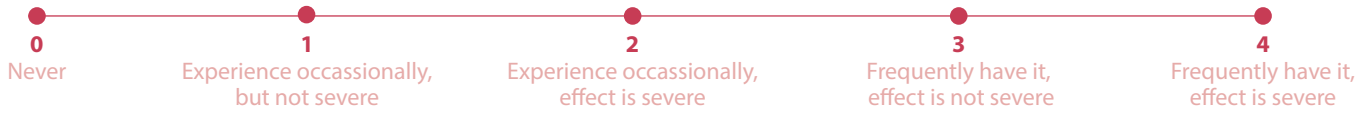
Do you dry clean your clothes frequently? No Yes

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.



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

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

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

ENERGY/ACTIVITY	SCORE
Fatigue	
Apathy	
Hyperactivity	
Restlessness	
TOTAL	

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

HEAD	SCORE
Headaches	
Faintness	
Dizziness	
Insomnia	
TOTAL	

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	

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

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

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

HEART	SCORE
Irregular heartbeat	
Rapid heartbeat	
Chest pain	
TOTAL	

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

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

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

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

OVERALL SCORE =

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.