Metabolic Detoxification Questionnaire

Part 1: Symptoms

Name: _____ Date: _____

Rate each of the following symptoms based on the last week using the point scale below:

0 Never or rarely 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

Digestive Tract	Nausea, vomiting	0 1 2 3 4
	Diarrhea	0 1 2 3 4
	Constipation	0 1 2 3 4
	Bloated feeling	0 1 2 3 4
	Heartburn	0 1 2 3 4
	Intestinal, stomach pain	0 1 2 3 4
	Digestive Total:	
Joints / Muscles	Pain or aches in joints	0 1 2 3 4
	Arthritis, joint swelling	0 1 2 3 4
	Stiff or limitation of movement	0 1 2 3 4
	Pain or aches in muscles	0 1 2 3 4
	Feeling of weakness or tired	0 1 2 3 4
	Joints / Muscles Total:	
Emotional	Mood swings	0 1 2 3 4
	Anxiety, fear, nervousness	0 1 2 3 4
	Anger, irritability, aggression	0 1 2 3 4
	Depression	0 1 2 3 4
	Emotional Total:	
Weight / Food	Binge eating, drinking	0 1 2 3 4
	Craving certain foods	0 1 2 3 4
	Excessive weight	0 1 2 3 4
	Compulsive eating, food addictions	0 1 2 3 4
	Water retention	0 1 2 3 4
	Underweight	0 1 2 3 4
	Weight / Food Total:	
Energy / Sleep	Fatigue, sluggishness	0 1 2 3 4
	Apathy, lethargy	0 1 2 3 4
	Hyperactivity	0 1 2 3 4
	Restlessness, achiness	0 1 2 3 4
	Sleep disturbances	0 1 2 3 4
	Energy / Sleep Total:	
Skin	Acne	0 1 2 3 4
	Hives, rashes, dry skin, redness	0 1 2 3 4
	Hair loss	0 1 2 3 4
	Flushing, hot flashes	0 1 2 3 4
	Excessive sweating	0 1 2 3 4
	Skin Total:	
Heart	Irregular or skipped heartbeat	0 1 2 3 4
	Rapid or pounding heartbeat	0 1 2 3 4
	Chest pain	0 1 2 3 4
	Heart Total:	
Other	Frequent illness	0 1 2 3 4
	Frequent or urgent urination	0 1 2 3 4
	Genital itch or discharge	0 1 2 3 4
	Other Total:	

Respiratory	Chest congestion	0 1 2 3 4
	Asthma, bronchitis	0 1 2 3 4
	Shortness of breath	0 1 2 3 4
	Difficulty breathing	0 1 2 3 4
	Respiratory Total:	
Eyes	Watery or itchy eyes	0 1 2 3 4
	Swollen, red, or sticky eyelids	0 1 2 3 4
	Bags or dark circles under eyes	0 1 2 3 4
	Blurred or restricted vision	0 1 2 3 4
	Eyes Total:	
Nose	Stuffy nose	0 1 2 3 4
	Sinus problems or dripping nose	0 1 2 3 4
	Hay fever	0 1 2 3 4
	Sneezing attacks	0 1 2 3 4
	Excessive mucus	0 1 2 3 4
	Nose Total:	
Mouth / Throat	Frequent, consistent coughing	0 1 2 3 4
	Gagging, need to clear throat	0 1 2 3 4
	Sore throat, hoarse, loss of voice	0 1 2 3 4
	Swollen or discolored tongue, gums, or lips	0 1 2 3 4
	Canker sores, other mouth sores	0 1 2 3 4
	Mouth / Throat Total:	
Ears	Itchy ears	0 1 2 3 4
	Earaches, ear infections	0 1 2 3 4
	Drainage from ear, waxy buildup	0 1 2 3 4
	Ringing in ears, hearing loss	0 1 2 3 4
	Ears Total:	
Head	Headaches	0 1 2 3 4
	Faintness or lightheadedness	0 1 2 3 4
	Dizziness	0 1 2 3 4
	Head Total:	
Cognitive	Poor memory, recall	0 1 2 3 4
	Confusion, poor comprehension	0 1 2 3 4
	Poor concentration	0 1 2 3 4
	Poor physical coordination	0 1 2 3 4
	Difficulty in making decisions	0 1 2 3 4
	Stuttering, stammering	0 1 2 3 4
	Slurred speech	0 1 2 3 4
	Learning disabilities	0 1 2 3 4
	Cognitive Total:	

Grand Total _____

For Practitioner Use Only:

Urinary pH_____

Metagenics

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) or 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 with 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 reactions that are not related to toxic load. Other mechanisms should be considered, such as inflammation/immune/allergy, 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.

Disclaimer: This questionnaire is for informational purposes only. It is not meant to diagnose or treat any condition or illness. All medical symptoms should be addressed by a qualified medical professional.