## Metabolic Detoxification Questionnaire

FirstLine Therapy

Lifestyle Medicine Programs by Metagenics

Name	me			Date	
Rate each of the	e following symptoms based on how y	ou've been feeling f	or the: □ Past 48 ho	ours   Past week   Past 30 days	
Point Scale	<ul> <li>o — Never or almost never have the symptoms</li> <li>1 — Occasionally have it; effect is not severe</li> </ul>		<ul> <li>2 — Occasionally have it; effect is severe</li> <li>3 — Frequently have it; effect is not severe</li> <li>4 — Frequently have it; effect is severe</li> </ul>		
Head	Headaches			Nausea, vomiting	
	Faintness		Tract	Diarrhea	
_	Dizziness			Constipation	
	Insomnia	Total		Bloated feeling	
Eyes	Watery or itchy eyes			Belching, passing gas	
	Swollen, reddened or sticky eyelids			Heartburn	
	Bags or dark circles under eyes			Intestinal/stomach pain	Total
	Blurred or tunnel vision (does not in	clude	Joints/	Pain or aches in joints	
	near- or farsightedness)	Total	Muscles	Arthritis	
			-	Stiffness or limitation of movement	
Nose	ltchy ears			Pain or aches in muscles	
	Earaches, ear infections			Feeling of weakness or tiredness	Total
	Drainage from ear				
	Ringing in ears, hearing loss	Total	Weight	Binge eating/drinking	
	C. ff			Craving certain foods	
	Stuffy nose			Excessive weight	
	Sinus problems			Compulsive eating	
	Hay fever			Water retention	
	Sneezing attacks	Takal		Underweight	Total
	Excessive mucus formation	Total	- Franci /	Cation of Lucasiah nasa	
outh/	Chronic coughing		Energy/ Activity	Fatigue, sluggishness Apathy, lethargy	
Throat	Gagging, frequent need to clear thro	at	Activity		
	Sore throat, hoarseness, loss of voice			Hyperactivity Restlessness	Total
	Swollen or discolored tongue, gums, or lips			Nestlessiless	Total
	Canker sores	Total	Mind	Poor memory	
				Confusion, poor comprehension	
Skin	Acne			Poor concentration	
	Hives, rashes, dry skin			Poor physical coordination	
	Hair loss			Difficulty in making decisions	
	Flushing, hot flashes			Stuttering or stammering	
	Excessive sweating	Total		Slurred speech	
	Irregular or skipped heartbeat		<u> </u>	Learning disabilities	Total
	Rapid or pounding heartbeat				
	Chest pain	Total	Emotions	Mood swings	
	Cilest paili	iotat		Anxiety, fear, nervousness	
Lungs	Chest congestion			Anger, irritability, aggressiveness	
	Asthma, bronchitis			Depression	Total
	Shortness of breath		Other	Frequent illness	
	Difficulty breathing	Total		Frequent or urgent urination	
				Genital itch or discharge	Total

**Grand Total** 

Urinary pH \_\_\_

## Metabolic Detoxification Questionnaire

1. Are you presently using prescription drugs?  ☐ Yes (1 pt.)  ☐ No (o pt.)	7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?  Yes (1 pt.)  Don't know (0 pt.)		
If yes, how many are you currently taking? (1 pt. each)	8. Do you feel ill after you consume even small amounts of alcohol?		
2. Are you presently taking one or more of the following over-the-counter drugs?  ☐ Cimetidine (2 pts.) ☐ Acetaminophen (2 pts.) ☐ Estradiol (2 pts.)	$\square$ Yes (1 pt.) $\square$ No (o pt.) $\square$ Don't know (o pt.)		
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.)	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.)		
6. Do you commonly experience "brain fog," fatigue, or drowsiness?  ☐ Yes (1 pt.) ☐ No (o pt.)  Part 3: Alkalizin	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 (o pt.) Don't know (o pt.)  Total		
Do you have a history of or currently have kidney dysfunction?  ☐ Yes (1 pt.) ☐ No (o pt.)	3. Are you currently taking diuretics or blood pressure medication?  ☐ Yes (1 pt.) ☐ No (o pt.)		
2. Have you ever been diagnosed with hyperkalemia?  ☐ Yes (1 pt.) ☐ No (o pt.)	Total		
Overall Scor	e Tabulation		
For Practitioner Use Only:  Part 1: Symptoms Grand Total (High >50; moderate 15-49;  Part 2: XTT Total (High >10; moderate 5-9; low <4)  Part 3: Alkalizing Assessment Total (High ≥1)  Urinary pH	low <14)		

Part 2: Xenobiotic Tolerability Test (XTT)

## 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 dysfuntion, 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.