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:						0
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:						0
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:						0
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:						0
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:						0
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:						0
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:						0
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:						0

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:						0
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:						0
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:						0
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:						0
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:						0
Head	Headaches	0	1	2	3	4	
	Faintness or lightheadedness	0	1	2	3	4	
	Dizziness	0	1	2	3	4	
	Head Total:						0
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:						0

Grand Total 0 _____

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 0

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 0

Overall Score Tabulation

For Practitioner Use Only:

Part 1: Symptoms Grand Total 0 (High ›50; moderate 15-49; low ‹14)
Part 2: XTT Total 0 (High ›10; moderate 5-9; low ‹4)
Part 3: Alkalizing Assessment Total 0 (High ≥1)
Urinary pH 0

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.

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