Detoxification Questionnaire

Patient Name_____ Date: _____

Rate each of the following symptoms based on your typical health profile for the **past month.**
Point Scale: 0 to 5; 0 (Never have the symptom) to **5** (Very frequently have the symptom)

HEAD
_____ Headaches
_____ Dizziness/ faintness
TOTAL _____

EYES
_____ Bags or dark circles under eyes
_____ Watery or itchy eyes
_____ Blurred or changed vision
TOTAL _____

EARS
_____ Itchy ears
_____ Ear aches/ infections
_____ Ringing in ears
_____ Hearing reduction
TOTAL _____

NOSE
_____ Frequent colds
_____ Stuffy nose/ congestion
_____ High mucus formation
_____ Sinus problems
_____ Hay fever
TOTAL _____

MOUTH/ THROAT
_____ Chronic coughing
_____ Frequent sore throat
_____ Hoarseness
_____ Dental problems
_____ Canker sores
TOTAL _____

SKIN
_____ Itchiness
_____ Acne/ eczema/ psoriasis
_____ Hives/ rashes/ dry skin
_____ Hair loss
_____ Flushing/ hot flashes
TOTAL _____

LUNGS
_____ Asthma/ bronchitis
_____ Shortness of breath
TOTAL _____

DIGESTIVE TRACT
_____ Bloating
_____ Burping
_____ **Gas/ Flatulence**
_____ Diarrhea
_____ Constipation/ straining
_____ Heartburn/ indigestion
_____ Nausea/ vomiting
_____ Blood or mucous in stool
_____ **Intestinal/ stomach pain**
TOTAL _____

JOINTS/ MUSCLE
_____ Joint pain/ stiffness
_____ Muscle pain/ stiffness
_____ Muscle spasms/ cramps
_____ Limited movement
_____ Numbness/ tingling
TOTAL _____

EMOTIONS
_____ Mood swings
_____ Anxiety/ nervousness
_____ Anger/ irritability
_____ Depression
TOTAL _____

OTHER
_____ Fatigue
_____ High stress
_____ Sugar cravings
_____ Poor concentration
_____ Poor memory
_____ Weight gain
_____ Poor sleep/ insomnia
_____ Appetite change
_____ Feel cold often
_____ Change in hair/ nails
TOTAL _____

HEART
_____ Irregular or rapid heartbeat
_____ High blood pressure
_____ Chest pain
_____ Heart disease
_____ Ankle swelling
TOTAL _____

GRAND TOTAL: _____

Nutritional Information

Foods you crave _____
Foods you eat often _____
Foods you avoid _____
Known Food Allergies _____
_____
_____

Water (glasses/day) _____
Coffee (cups/day) _____
Tea (cups/day) _____
Juice (glasses/day) _____
Pop (glasses/day) _____
Milk (glasses/day) _____
Dairy Intake (what type) _____
Alcohol (how much) _____
Bread (how much) _____
Sweeteners _____

Typical Meals

Breakfast: _____
_____
_____
_____

Lunch: _____
_____
_____
_____

Dinner: _____
_____
_____
_____
_____

Snacks: _____
_____

Treats: _____
_____

Other Information

Do you Smoke? _____
Scars (where) _____