DETOXIFICATION QUESTIONNAIRE

Patient Name:_____ **Date:**_____

Rate each of the following symptoms based on your typical health profile for the specified duration:

☐ Past month ☐ Past week ☐ Past 48 hours

Point Scale:
0 – Never or almost never 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

I. Medical Symptoms Questionnaire (MSQ)

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia **TOTAL** _____

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision **TOTAL** _____

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss **TOTAL** _____

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation **TOTAL** _____

MOUTH / THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores **TOTAL** _____

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating **TOTAL** _____

HEART
_____ Chest pain
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat **TOTAL** _____

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **TOTAL**

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain **TOTAL** _____

JOINTS / MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Feeling of weakness or tiredness
_____ Pain or aches in muscles **TOTAL** _____

WEIGHT
_____ Binge eating / drinking
_____ Craving certain foods
_____ Excessive weight
_____ Water retention
_____ Underweight
_____ Compulsive eating **TOTAL** _____

ENERGY / ACTIVITY
_____ Fatique, sluggishness
_____ Confusion, poor comprehension
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ Poor concentration
_____ Poor physical condition **TOTAL** _____

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression **TOTAL** _____

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge **TOTAL** _____

GRAND TOTAL **TOTAL** _____