Detoxification Questionnaire

Name **Date**

INSTRUCTIONS: Please circle the number which best describes the frequency or severity of your complaints. Leave the question blank if it does not apply to you.
0 = RARELY OR NEVER EXPERIENCE SYMPTOM 1 = MILD 2 = MODERATE 3 = SEVERE

PART 1: Detoxification Function

Section A:

1	Heartburn	0 1 2 3
2	Bloating of the abdomen	0 1 2 3
3	Belching	0 1 2 3
4	Foul-smelling gas	0 1 2 3
5	Nausea/vomiting	0 1 2 3
6	Constipation	0 1 2 3
7	Diarrhea	0 1 2 3
8	Bad breath	0 1 2 3
9	Headaches	0 1 2 3
10	Excessive mucous production	0 1 2 3
11	Watery or itchy eyes	0 1 2 3
12	Swollen, red eyes	0 1 2 3
13	Dark circles under the eyes	0 1 2 3
14	Chronic sore throat	0 1 2 3
15	Muscle aches and pains	0 1 2 3
16	Fatigue	0 1 2 3
17	Stuffy or runny nose	0 1 2 3
18	Sinus problems	0 1 2 3
19	Excessive sneezing	0 1 2 3
20	Joint pains	0 1 2 3
21	Depression	0 1 2 3
22	Anxiety	0 1 2 3
23	Irritability	0 1 2 3
24	Hyperactivity	0 1 2 3
25	Insomnia	0 1 2 3
26	Acne	0 1 2 3
27	Hives/rashes	0 1 2 3
28	Hard time breathing	0 1 2 3
29	Chest pains	0 1 2 3
30	Irregular or skipped heartbeat	0 1 2 3
31	Hair loss	0 1 2 3
32	Frequent urination	0 1 2 3
33	Frequent illness	0 1 2 3
34	Mood swings	0 1 2 3
35	Excess anger/fear	0 1 2 3
36	Poor memory	0 1 2 3
37	Overall poor feeling	0 1 2 3
38	Lack of energy	0 1 2 3
39	Frequent colds	0 1 2 3
40	Ear infections or earaches	0 1 2 3
41	Hayfever	0 1 2 3
42	Environmental sensitivity	0 1 2 3
43	Asthma/bronchitis	0 1 2 3
44	Arthritis	0 1 2 3
45	Excess weight	0 1 2 3

Compliments of: Kimberly Bender DC DACBN CCN 727-559-7881