FirstLine Therapy®

Metabolic Detoxification Questionnaire

Name _____ Date _____

Rate each of the following symptoms based upon your typical health profile:

Point Scale

0 — Never or almost never have the symptoms
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	Date	Date	Date	Date	Date	Date	Date	Date
Nausea or vomiting								
Diarrhea								
Constipation								
Bloated feeling								
Belching, passing gas								
Heartburn								
Total								

Ears								
Itchy ears								
Earaches, ear infection								
Drainage from ear								
Ringing in ears, hearing loss								
Total								

Emotions								
Mood swings								
Anxiety, fear, nervousness								
Anger, irritability								
Depression								
Total								

Energy/Activity								
Fatigue, sluggishness								
Apathy, lethargy								
Hyperactivity								
Restlessness								
Total								

Eyes								
Watery, itchy eyes								
Swollen, reddened/sticky eyelids								
Dark circles under eyes								
Blurred/tunnel vision								
Total								

Head								
Headaches								
Faintness								
Dizziness								
Insomnia								
Total								

Lungs								
Chest congestion								
Asthma, bronchitis								
Shortness of breath								
Difficulty breathing								
Total								

Heart								
Skipped heartbeats								
Rabid heartbeats								
Chest pain								
Total								

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Mind

Poor memory								
Confusion								
Poor concentration								
Poor coordination								
Difficulty making decisions								
Stuttering, stammering								
Slurred speech								
Learning disabilities								
Total								

Mouth/Throat

Chronic coughing								
Gagging, frequent need to clear throat								
Sore throat, hoarse								
Swollen or discolored tongue, gum, lips								
Canker sores								
Total								

Nose

Stuffy nose								
Sinus problems								
Hay fever								
Sneezing attacks								
Excessive mucus								
Total								

Skin

Acne								
Hives, rashes, dry skin								
Hair loss								
Flushing or hot flashes								
Excessive sweating								
Total								

Joints/Muscles

Pain or aches in joints								
Arthritis								
Stiffness, limited movement								
Pain, aches in muscles								
Feeling of weakness of tiredness								
Total								

Weight

Binge eating/drinking								
Craving certain foods								
Excessive weight								
Compulsive eating								
Water retention								
Underweight								
Total								

Other

Frequent illness								
Frequent or urgent urination								
Genital itch, discharge								
Compulsive eating								
Total								

Grand Total								

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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 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 on 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 _____

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 _____

Overall Score Tabulation

For Practitioner Use Only:

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

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.