**Miranda Naturopathic Clinic**
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# DETOXIFICATION QUESTIONNAIRE

Name -_____ Date _____

*Rate each of the following symptoms based on how you generally feel.*

*Point scale:* *0 – Never or almost never have this 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*

**ENERGY / MIND**
- Fatigue, sluggishness ____
- Decreased stamina ____
- Restlessness ____
- No motivation ____
- Hard to make decisions ____
- Poor or foggy memory ____
- Confusion / slow thinking ____
- Poor concentration ____
- **TOTAL** ____

**WEIGHT**
- Excess weight ___
- Underweight ___
- Binge eating / drinking ___
- Craving certain foods ___
- Water retention ___
- Compulsive eating ___
- **TOTAL** ___

**DIGESTIVE TRACT**
- Nausea, vomiting ___
- Belching , burping ___
- Constipation ___
- Diarrhea ___
- Bloated or gassy ___
- Heartburn, acid reflux ___
- Abdominal pain/cramps ___
- Canker Sores ___
- **TOTAL** ___

**MOOD / TEMPERAMENT**
- Mood swings ___
- Anxiety, nervousness ___
- Overwhelmed, agitated ___
- Depression ___
- Anger, irritable, rage ___
- **TOTAL** ___

**IMMUNE SYSTEM**
- Frequent infections ___
- Long time to recover ___
- Chest or sinus congestion ___
- Post nasal drip ___
- Stuffy nose ___
- Asthma ___
- Allergies / hay fever ___
- Chronic coughing ___
- Swollen glands or nodes ___
- **TOTAL** ____

**MUSCLE & JOINTS**
- Pain or aches in joints ___
- Pain or aches in muscle ___
- Stiffness or swelling ___
- Arthritis ___
- Feeling weakness ___
- **TOTAL** ____

**HEAD**
- Headaches, migraines ___
- Faintness ___
- Dizziness ___
- Insomnia ___
- **TOTAL** ____

**SKIN**
- Acne, eczema, psoriasis ___
- Hives, rashes, dry skin ___
- Hair loss ___
- Extra or offensive sweating ___
- **TOTAL** ____

**EYES**
- Watery or itchy eyes ___
- Dark circles under eyes ___
- Swollen sticky eyelids ___
- **TOTAL** ____

**EARS**
- Itchy ears ___
- Earaches, ear infections ___
- Ringing of ears ___
- **TOTAL** ____

**GENITOURINARY**
- Frequent urination ___
- Genital itchiness, discharge ___
- Infections – vaginal, bladder ___
- **TOTAL** ____

**OTHER** – (*can be current or past*)
- Suffer from Auto immune condition ___
- Suffer from fibroids or endometriosis ___
- Suffer from PMS or heavy periods ___
- Suffer from infertility ___
- Suffer with cancer ___
- Suffer from chemical sensitivities ___
- Suffer from food intolerances or allergies ___
- Suffer from Chronic fatigue syndrome ___
- Suffer from Fibromyalgia ___
- Suffer from alcoholism ___
- **TOTAL** ____

**HABITS** – (*Give yourself 0 for NO or 3 for YES*)
- Eat less than 3 cups of vegetables per day ___
- Drink more than 3 glasses of alcohol per day ___
- Drink more than 1 cup of coffee per day ___
- Eat fast or processed food more than 1x week ___
- Take prescription medication regularly ___
- Take birth control pill ___
- Take other synthetic hormones ___
- Smoke or use rec. drugs more than 1 x week ___
- Drink less than 7-8 glasses per day ___
- **TOTAL** ____

***Scores: < 18 detox is a LOW priority; 19 to 52 detox is a MODERATE priority; >53 detox is a HIGH priority***

**GRAND TOTAL _____**