Metabolic Clearing Therapy

Answer each question with one of the following, and then total all answers for each section at the right. Then add all of the boxes to give a grand total a the end.

0=Never almost never.
1=Occasionally, not severe.
2=Occasionally, is severe.
3=Frequent, not severe.
4=Frequent, is severe.

DIGESTIVE TRACT

Nausea or vomiting ___
Diarrhea ___
Constipation ___
Bloated feeling ___
Heartburn ___
Belching, or passing gas ___

Total ☐

EARS

Itchy ears ___
Earaches, infections ___
Drainage from ear ___
Ringing in ears ___
Hearing loss ___

Total ☐

EMOTIONS

Mood swings ___
Anxiety ___
Fear or nervousness ___
Depression ___

Total ☐

ENERGY

Fatigue, sluggishness ___
Apathy, lethargy ___
Hyperactivity ___
Restlessness ___

Total ☐

EYES

Watery of itchy eyes ___
Swollen, reddened or sticky eyelids ___
Bags/dark circles under eyes ___
Blurred or tunnel vision ___

Total ☐

HEAD

Headaches ___
Faintness ___
Dizziness ___
Insomnia ___

Total ☐

HEART

Irregular or skipped heartbeats ___
Rapid or pounding heartbeat ___
Chest pain ___

Total ☐

JOINTS/MUSCLES

Pain or aches in joints __
Arthritis __
Stiffness/limited motion __
Pain/aches in muscles __
Feeling weakness/tiredness __

Total

LUNGS

Chest congestion __
Asthma, bronchitis __
Shortness of breath __
Difficulty breathing __

Total

MIND

Poor memory __
Confusion, poor comprehension __
Poor concentration __
Poor physical coordination __
Difficulty making decisions __
Stuttering/stammering __
Slurred speech __
Learning disabilities __

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

NOSE

Stuffy nose __
Sinus problems __
Hayfever __
Sneezing attacks __
Excessive mucous formation __

Total

SKIN

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

Total

WEIGHT

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

Total

OTHER

Frequent illness __
Frequent/urgent urination __
Genital itch or discharge __

Total

GRAND TOTAL

THE DETOX RISK QUESTIONNAIRE

Answer each question with one of the following, and then total all answers at the end.

Scale 0 – 4 (a=0, b=1, c=3, d=4)

In describing my own elimination system I would say:

a. I have regular formed soft bowel movements twice a day
b. I have one bowel movement a day
c. I have hard, difficult to pass movements everyday or every other day
d. I am constipated and only go every other day or less often

Bowel Movements: Score

Subtotal

a. I urinate large volumes or clear urine regularly throughout the day
b. I urinate moderate amounts of yellow colored urine 3-4 times a day
c. I urinate small amounts of dark, strong smelling urine a few times a day
d. I only go once or twice a day, very dark and strong smelling urine

Urination: Score

Subtotal

a. I sweat profusely daily though exercise or saunas or hot baths
b. I sweat profusely 2-3 times a weak
c. I sweat lightly and only a few times a week
d. I almost never break a real sweat

Sweat: Score

Subtotal

I have the following symptoms or conditions:

Scale 0 = no, 1 = yes

a. Headaches ____
b. Joint pains ____
c. Chronic cough ____
d. Fluid retention or anemia ____
e. Sore throat ____
f. Wheezing ____
g. Tight neck ____
h. Backaches ____
i. Muscle aches ____
j. Fibromyalgia ____
k. Chronic fatigue syndrome ____
l. Angina ____
m. High cholesterol ____
n. Frequent cold or infection ____
o. Irritated eyes ____
p. Sinus congestion ____
q. Environmental sensitivities

(intolerance to smells and odors) ____
r. Chronic runny nose or postnasal drainage ____
s. Anxiety ____
t. Insomnia ____
u. Mood problems (anxiety, depression) ____
v. Memory or concentration problems ____
w. Skin rashes ____
x. Fatigue ____
y. Indigestion or Nausea ____
z. Bad breath ____
aa. I drink too much alcohol (> 3 drinks a week) ____
bb. I use street drugs ____

Subtotal

Are you exposed to any of the following at home, work, or school?
Scale 0 = no, 1 = yes

a. I don't drink purifies or filtered water or bottled water ____
b. Spring, well, or municipal water ____
c. Damp musty smell, damp cellar, mildew and/or molds ____
d. Gas appliances or heater, wood stove, coal stove, forced air heating, kerosene heater, smokestacks, dump, air pollution ____
e. Cell phones, computers, remote control, electric radio/alarm clocks, Microwave tower, High power lines, electric blankets ____
f. Fresh tar/ asphalt ____
g. Feather pillows/comforters, foam pillows or mattresses ____
h. Mothballs ____
i. Synthetic carpeting or other carpeting ____
j. New or recent construction or renovation ____
k. Pressure-treated wood, particleboard, urea foam insulation (UFFI) ____
l. Amalgam (silver) dental fillings ____
m. Pesticides (sprays/exterminators), lawn care chemicals, dry-cleaning ____
n. Polyester blends ____

Subtotal

The statement that best describes my light exposure is:
Scale a = 0, b = 1

a. Mostly natural light (the sun, o through windows) or full spectrum lighting ____
b. Mostly incandescent (light bulbs) or fluorescent ____

Subtotal

Are you bothered by?
Scale 0 = no, 1 = yes

a. Gasoline or diesel fumes ____
b. Perfumes, new cars smells, fabric stores, dry cleaning, hair spray or other strong odors ____
c. Soaps, detergents ____
d. Tobacco smoke ____
e. Chlorinated water ____
f. Dust ____
g. Cats, dogs ____
h. Pollen (tree, grass, ragweed) ____
i. Molds ____

Subtotal

Do you have a negative reaction when you consume?
Scale 0 = no, 1 = yes

a. Foods containing MSG ____
b. Foods containing sulfites (wine, salad bars, dried fruit) ____
c. Sodium benzoate (preservative) ____
d. Red wine, cheese, bananas or chocolate ____
e. Aspirin ____
f. Even a small amount or alcohol ____
g. Eating food with garlic and onions ____
h. Experience a strange urinary odor after eating asparagus ____

Subtotal

When you drink coffee or caffeine containing substances
Scale 0 = no, 1 = yes

a. I feel wired up ____
b. Feel an increase in joint and muscle aching ____
c. Have hypoglycemic symptoms ____

Subtotal

Do you regularly consume any of the following substances or medications?
Scale 0 = no, 1 = yes

a. Acetaminophen ____
b. Acid blocking drugs (Tagamet, Zantac, Pepcid, Prilosec, Prevacid) ____
c. Hormone modulating medications in pills, patches or creams (the pill, estrogen, progesterone, prostate medication) ____
d. Ibuprofen or naproxen ____
e. Arthritis drugs (Vioxx, Celebrex, Bextra) ____

f. Drugs for Irritable Bowel Syndrome, Colitis or Crohn's disease ____
g. Recurrent headaches ____
h. Allergy symptoms ____
i. Nausea, diarrhea or indigestion ____
j. Tobacco ____
k. Alcohol ____

Subtotal

Have you
Scale 0 = no, 1 = yes

a. Ever gotten jaundiced (turned yellow) when not eating for a while or fasting? ____
b. Ever turned yellow for any reason (jaundice) ____
c. Ever been told you have Gilbert's syndrome ____

Subtotal

Are you allergic to antibiotics ;ile penicillin, sulfa drugs, and tetracyclines?
Scale 0 = no, 1 = yes

a. Yes
b. No

Subtotal

Do you have a personal or family history of?
Scale 0 = no, 1 = yes

a. Breast cancer ____
b. Smoking induced lung cancer ____
c. Other type of cancer ____
d. Prostate problems ____
e. Food allergies, sensitivities or intolerances ____
f. Environmental sensitivities ____
g. Parkinson's, Alzheimer's or other motor neuron diseases, or multiple sclerosis ____
h. Asthma ____
i. Lupus, rheumatoid arthritis, Ankylosing Spondylitis or other autoimmune disease ____

Subtotal

Do you have now or have you experienced in the past (for women only)
Scale 0 = no, 1 = yes
a. breast tenderness associated with your menstrual period
b. other PMS symptoms

Subtotal

Grand Total

Indications of Results:

0-25: You have a low overall risk for problems relating to impaired detoxification

26-50: Your detoxification system is at minimal-average risk; I recommend that you do the detoxification program at least once every 3 months

51-75: You are at significant risk for diseases and symptoms related to impaired detoxification. I suggest that you do the 6 week detoxification program

76-100: You likely need further testing and medical supervision for detoxification, most people will feel better doing the 6 week detoxification program. Usually you will need to repeat the 6 week program within 30 days