QUESTIONNAIRE: DETOXIFICATION REQUIREMENTS

NAME: _____ DATE: _____

Please review the list below and circle the most appropriate answer.

SECTION 1A: DIET, LIFESTYLE, SYMPTOMS and MEDICAL HISTORY						
Each answer has a value:	0	1	2	3	4	5
1. How much of the food you eat each week is 'spray-free' or organically grown or raised?	All or most		Around half		Some	None
2. How often do you eat fruit? One serve = one handful	2 or more serves daily	1 serve daily		Weekly	Monthly	Never or rarely
3. How often do you eat vegetables (excluding potatoes)? One serve = one handful	5 or more serves daily	2-4 serves daily	Daily	Weekly	Monthly	Never or rarely
4. How often do you eat animal products? (e.g. dairy foods, eggs, poultry, red meat or fish)	Never or rarely	Monthly	Weekly	Once a day	Twice daily	Most meals
5. Do you drink filtered water?	Always or mostly	Sometimes	Never or rarely			
6. How often would you have tinned food?	Never or rarely	Monthly	Weekly	Daily		
7. How often do you eat 'fast' or 'junk' food? (e.g. takeaway, deep fried, snack food)	Never or rarely	Monthly		Weekly		Daily
8. How often do you drink more than 4 standard alcoholic drinks in one session?	Never or rarely		Monthly	Weekly: 1-2 times	Weekly: 3-6 times	Daily
9. Do you use 'social' or 'recreational' drugs? (e.g. marijuana, ecstasy, etc.)	Never	Rarely		Monthly	Weekly	Daily
10. How many 'personal care' products do you use? (e.g. soap, cleanser, shampoo, conditioner, antiperspirants, moisturiser, special creams, cosmetics: foundation, eyeliner, eyeshadow, lipstick, perfumes)	0-5 products daily		6-10 products daily		11-20 products	21 or more products daily
11. Do you feel unusually tired?	Never	Sometimes		Often		Always
12. Do you have any skin issues? (e.g. acne, eczema, rashes)	None	Slight	Moderate		Severe	
13. Do you suffer from headaches or migraines?	Never or rarely			Monthly	Weekly	Daily
14. Do you suffer from allergies or asthma?	None	Slight		Moderate		Severe
TOTALS:						
	TOTAL FOR SECTION 1A:					

SECTION 1B: MEDICAL HISTORY: DO YOU HAVE, OR IS THERE A PERSONAL OR FAMILY HISTORY OF:				
	No Personal or Family History	Family History	Personal History (Past)	Personal History (Current)
Cancer	0	2	7	10
Autoimmune disorders (including Type 1 diabetes)	0	3	5	10
Hormonal disorders (e.g. fibroids, endometriosis, reproductive problems, thyroid)	0	3	5	10
Diabetes (Type 2)	0	2	4	8
Fibromyalgia and/or chronic fatigue syndrome	0	2	4	8
Heart disease	0	1	3	5
TOTALS:				
	TOTAL FOR SECTION 1B:			

SECTION 2: GUT						
Each answer has a value:	0	1	2	3	4	5
1. Do you get diarrhoea (loose and/or frequent stool)?	Rarely		Monthly		Weekly	Daily
2. Is there mucus or blood in your bowel motion?	Never		Rarely	Monthly	Weekly	Daily
3. Do you suffer from heartburn, burping, nausea or reflux/acid regurgitation requiring antacid medication?	Rarely	Monthly		Weekly	Daily	
4. Do you experience abdominal bloating, fullness or pain?	Rarely	Monthly		Weekly	Daily	
5. Do you feel a sensation of incomplete emptying of the bowel?	Rarely	Monthly	Weekly	Daily		
6. Do you experience constipation (less than one bowel motion a day)?	Rarely	Monthly	Weekly	Daily		
Have you been diagnosed with a gut disorder such as:						
7. Small intestinal bacterial overgrowth (SIBO)	No					Yes
8. Inflammatory bowel disease (IBD – ulcerative colitis, Crohn's disease) or irritable bowel syndrome (IBS)	No					Yes
9. Peptic ulcer (stomach/gastric, duodenal)	No				Yes	
10. Do you have any food allergies or sensitivities? (e.g. gluten sensitivity, coeliac disease, dairy intolerance)	No					Yes
11. Do you suffer from thrush (candida)?	Never	Rarely		Monthly	Weekly	Daily
12. Do you take pharmaceutical anti-inflammatory or pain relief medicines?	Never	Rarely	Monthly		Weekly	Daily
Have you had a course of any of the following in the last 5 years?						
13. Antibiotics	No			1-3 courses		More than 3 courses
14. Chemotherapeutic agents	No				Yes	
15. Radiotherapy	No					Yes
TOTALS:						
	TOTAL FOR SECTION 2:					

SECTION 3: ENVIRONMENTAL TOXINS/LIVER						
Each answer has a value:	0	1	2	3	4	5
1. Do you have any liver/gallbladder disease? (e.g. gall stones, hepatitis, fatty liver or jaundice - are the whites of your eyes yellowed?)	No					Yes
2. Are you or have you been exposed to heavy traffic, exhaust fumes and pollution? (e.g. living near a main road, exercising along main roads, commuting, working on roads or in car parks)	Rarely		Monthly	Weekly	Daily - a few hours	Daily - most of the day
3. Are you or have you been exposed to insecticides, pesticides, or herbicides? (e.g. fly sprays, garden sprays, termite or flea treatments; working on a golf course, orchard or farm)	Rarely		Occasional		Weekly	Daily (occupational)
4. Are you or have you been exposed to paints, solvents, glues, nail polish, hair dyes and similar products?	Rarely	Monthly		Weekly		Daily (occupational)
5. Do you use cleaning products? (e.g. disinfectants, detergents, degreasers, polishes and similar products)	Rarely	Monthly		Weekly		Daily (occupational)
6. Do you consume food or drink from plastic or plastic-lined containers? (e.g. bottled water, disposable coffee cups, canned food, takeaway food containers)	No	Monthly	Weekly	Daily		
7. Do you experience bouts of anger or irritability?	Rarely	Monthly	Weekly	Daily		
8. Do you have a new (less than 3 years old) car, furniture or carpets?	No				Yes	
9. Have you lost/are you trying to lose a significant amount of weight?	No				Yes	
10. Do you have trouble losing weight?	No			Yes		
11. Are any of your symptoms worsened by exposure to substances such as alcohol, cigarette smoke, vehicle exhaust, perfumes and cleaning products (e.g. certain aisles in supermarkets or areas in department stores) or similar?	No	Slightly		Moderately		Severely
TOTALS:						
	TOTAL FOR SECTION 3:					

SECTION 4: METALS						
Each answer has a value:	0	1	2	3	4	5
1. Have you ever been diagnosed with heavy metal toxicity? (e.g. lead, mercury, cadmium, arsenic, or similar)	No					Yes
2. Have you worked, or do you work, with metals? (e.g. as a plumber, gas fitter, foundry worker, welder; or in electroplating, stained-glass (leadlight) fabrication etc.)	No		Occasional		Regularly (hobby)	Daily (occupational)
3. Have you lived, or do you live, near a mine, industrial area, paint manufacturing, smelter, forge or foundry?	No				Yes	
4. Do you have difficulties thinking, adding up numbers, learning or reasoning, or finding the right word to express yourself?	Never or rarely		Monthly		Weekly	Daily
5. Do you have trouble remembering things?	Never or rarely		Monthly		Weekly	Daily
6. Do you get numbness, tingling or weakness in parts of the body?	Never or rarely		Monthly		Weekly	Daily
7. Do you eat large deep-sea predator fish such as tuna, swordfish and shark (flake)?	No	Rarely (less than once a month)		Once or twice a month	Weekly	Several times a week
8. Have you been exposed to arsenic treatments such as anti-termite dusting, working with or burning treated timber?	No					Yes
9. Do you smoke tobacco? (e.g., cigarettes, cigars, pipe)	Never	Past smoker		Socially (weekends)	A few most days	A packet + daily
10. Do you have, or have you ever had, mercury amalgam dental fillings (silver/grey, not white)?	No			Previously removed	1-3 fillings	More than 3 fillings
11. Have you ever renovated an old house? (e.g. exposure to old paint, plumbing)	No			Yes		
TOTALS:						
	TOTAL FOR SECTION 4:					

PART	1A - GENERAL	1B - HISTORY	2 - GUT	3 - LIVER	4 - METALS	TOTAL SCORE
TOTALS:						

INTERPRETING THE SCORES: DO YOU NEED TO DETOX?

If total score below 40:	Low priority (Express Detox may be indicated)
If total score between 40 and 70:	Medium priority
If total score above 70:	High priority

INTERPRETING THE SCORES: DO YOU NEED A SPECIALISED DETOX?

If sections 2, 3, and 4 each score less than 20:	Integrated Detox
If section 2 score above 20:	Specialised Gut Detox
If section 3 score above 20:	Specialised Liver Detox
If section 4 score above 20:	Specialised Chelation Detox