



Environmental Detoxification Questionnaire

Date: _____

Patient Name: _____

Presenting Complaints:

Please circle the appropriate answer.

Environment

Are you very sensitive to fragrances, exhaust fumes or strong odours?	Yes	No
Are you significantly bothered by video display terminals and fluorescent lights?	Yes	No
In your work or home environment, are you exposed to any chemicals or electromagnetic radiation?	Yes	No
Do you have a known history of significant exposure to any harmful chemicals like herbicides, insecticides, pesticides, styrene, solvents or other harmful substances?	Yes	No

Lifestyle Choice

Do you smoke or use tobacco in any form regularly/daily?	Yes	No
Do you regularly drink two or more alcoholic beverages per day?	Yes	No
Do you consume caffeine on a daily basis?	Yes	No
Do you react adversely when you consume caffeinated beverages	Yes	No
Does your urine have an unusual odour after eating asparagus?	Yes	No
Do you react adversely to red wine, cheese, bananas, chocolate yeast spreads, pork or tomatoes? (vaso-active amines)	Yes	No
Do you eat grapefruit regularly and feel poorly after?	Yes	No
Do you feel unwell after foods with onions or garlic in them?	Yes	No
Do you take paracetamol regularly for headaches or other pain relief?	Yes	No
Do you use any hormonal medications, in the form of pills, patches or creams?	Yes	No
Do you regularly practice any form of stress reduction, yoga, or meditation?	Yes	No

Take into account that patients will generally present in one of 4 main categories:

1. Mild detox problems 2. Moderate 3. Severe 4. Chronic detoxification problem.

NB: This Detoxification Questionnaire is open to interpretation by the practitioner taking into account the patient's complete medical history and current condition.