

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 at 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 _____
Bloating 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 or 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 week
- 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 of 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