

QUESTIONNAIRE: DETOXIFICATION REQUIREMENTS

Name (optional):

Date:

VALUE EQUIVALENT

0 = Rarely/Never; 1 = Occasionally/Once every other week; 2 = Sometimes/Once or twice a week;
3 = Often/A few times a week; 4 = Always/Daily

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

SECTION 1	0	1	2	3	4
Do you consume less than five cups of vegetables and/or salad daily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you eat non-organic foods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat processed meat, or fatty meat such as ham, salami, devon or sausages?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink more than four alcoholic drinks in one sitting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use 'social' or 'recreational' drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your diet contain soft drink and/or junk food (e.g. chips, chocolate, biscuits, lollies, cakes, cookies)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you consume food or drink from plastic, plastic-lined containers, tin or aluminum? (e.g. bottled water, disposable coffee cups, canned food, aluminum cans, takeaway food containers)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you, or have you been, exposed to insecticides, pesticides or herbicides in the last 12 months (e.g. had your home sprayed for pests, or used weed killing sprays, termite or flea treatments)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you, or have you been, exposed to heavy traffic, exhaust fumes and pollution?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use synthetic cleaning products at home (e.g. disinfectants, detergents, bleach, polishes and similar products)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you regularly exposed to nail polish, hair dyes and similar products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from fatigue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from headaches or migraines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently suffer with any skin conditions (e.g. eczema, acne and/or rosacea)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from allergies or asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience PMS, irregular periods or heavy periods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you lost/are you trying to lose a significant amount of weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble losing weight or regain lost weight quickly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you pass stools that are slightly loose or not well-formed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel a sensation of incomplete emptying of the bowel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there mucus or blood in your bowel motion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been on a course of antibiotics in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you take pharmaceutical anti-inflammatory or pain relief medicines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking or have you previously been on proton pump inhibitors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you or your partner planning on becoming pregnant in the next six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you done a Practitioner guided detoxification in the past six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total					
Section 1 Total					

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SECTION 2	0	1	2	3	4
Do you experience abdominal bloating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience excessive burping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from abdominal pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from excessive flatulence, wind or foul smelling wind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience nausea or loss of appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from heartburn, indigestion or reflux/acid regurgitation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get diarrhoea (loose and/or frequent stool)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience constipation (less than one bowel motion a day)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with irritable bowel syndrome or inflammatory bowel disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from oral or vaginal thrush (candida)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total					
Section 2 Total					

SECTION 3	0	1	2	3	4
Do you have occupational or regular exposure to pesticides, herbicides, paints, solvents, glues, petroleum products, industrial cleaning products; or do you work with other chemicals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? Or have you previously smoked regularly in the last four years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a new (less than one year old) car, furniture or carpets; or have you ever renovated an old house?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 department stores) or similar?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do health complaints reappear or worsen during weight loss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulties thinking, adding up numbers, learning or reasoning, or finding the right word to express yourself? Do you have trouble remembering things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get numbness, tingling or weakness in parts of your body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat large deep-sea predator fish such as tuna, swordfish and/or shark (flake)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have, or have you ever had, mercury amalgam dental fillings (silver/grey, not white)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total					
Section 3 Total					