



<p><b>SKIN</b> _____ Acne</p> <p>_____ Hives, rashes, dry skin</p> <p>_____ Hair Loss</p> <p>_____ Flushing, hot flashes</p> <p>_____ Excessive sweating      <b>TOTAL</b> _____</p> <hr/> <p><b>HEART</b> _____ Chest Pain</p> <p>_____ Irregular or skipped heart beat</p> <p>_____ Rapid or pounding heartbeat</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>LUNGS</b> _____ Chest congestion</p> <p>_____ Asthma, bronchitis</p> <p>_____ Shortness of breath</p> <p>_____ Difficulty breathing      <b>TOTAL</b> _____</p> <hr/>	<p><b>MIND</b> _____ Poor Memory</p> <p>_____ Confusion, poor concentration</p> <p>_____ Difficulty in making decisions</p> <p>_____ Stuttering or stammering</p> <p>_____ Slurred speech</p> <p>_____ Learning disabilities</p> <p>_____ Poor concentration</p> <p>_____ Poor physical coordination</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>EMOTIONS</b> _____ Mood swings</p> <p>_____ Anxiety, fear, nervousness</p> <p>_____ Anger, irritability, aggressiveness</p> <p>_____ Depression      <b>TOTAL</b> _____</p> <hr/> <p><b>OTHER</b> _____ Frequent illness</p> <p>_____ Frequent or urgent urination</p> <p>_____ Genital itch or discharge</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>GRAND TOTAL</b> _____ <b>TOTAL</b> _____</p> <hr/>
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## II. Xenobiotix Tolerability Test (XTT)

<p>1. Are you presently using prescription drugs?</p> <p><input type="checkbox"/> Yes (1 pt.)</p> <p>If yes, how many are you currently taking? _____ (1 pt. each)</p> <p><input type="checkbox"/> No (0 pt.)</p> <hr/> <p>2. Are you presently taking one or more of the following over-the-counter drugs?</p> <p><input type="checkbox"/> Cimetidine (2 pts.)</p> <p><input type="checkbox"/> Acetaminophen (2 pts.)</p> <p><input type="checkbox"/> Estradiol (2 pts.)</p> <hr/> <p>3. If you have used or currently using prescription drugs, which of the following scenarios best represents your response to them?</p> <p><input type="checkbox"/> Experience side effects, drug (s) is (are) efficacious at lowered dose (s) (3 pts.)</p> <p><input type="checkbox"/> Experience side effects, drug (s) is (are) efficacious at usual dose (s) (2 pts.)</p> <p><input type="checkbox"/> Experience no side effects, drug (s) is (are) usually not efficacious (2 pts.)</p> <p><input type="checkbox"/> Experience no side effects, drug (s) is (are) usually efficacious (0 pt.)</p>	<p>6. Do you commonly experience "brain fog", fatigue, or drowsiness?</p> <p><input type="checkbox"/> Yes (1 pt.)    <input type="checkbox"/> No (0pt)</p> <hr/> <p>7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?</p> <p><input type="checkbox"/> Yes (1 pt.)    <input type="checkbox"/> No (0pt)    <input type="checkbox"/> Don't know (0 pt)</p> <hr/> <p>8. Do you feel ill after you consume even small amounts of alcohol?</p> <p><input type="checkbox"/> Yes (1 pt.)    <input type="checkbox"/> No (0pt)    <input type="checkbox"/> Don't know (0 pt)</p> <hr/> <p>9. Do you have a personal history of:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Environmental and/or chemical sensitivities (5 pts)</li> <li><input type="checkbox"/> Chronic fatigue syndrome (5 pts)</li> <li><input type="checkbox"/> Multiple chemical sensitivity (5 pts)</li> <li><input type="checkbox"/> Fibromyalgia (3 pts)</li> <li><input type="checkbox"/> Parkinson's type symptoms (3 pts)</li> <li><input type="checkbox"/> Alcohol or chemical dependence (2pts)</li> <li><input type="checkbox"/> Asthma (1 pt)</li> </ul> <hr/> <p>10. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents.</p> <p><input type="checkbox"/> Yes (1 pt.)    <input type="checkbox"/> No (0pt)</p>
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<p>4. Do you currently use or within the last 6 months had you regularly used tobacco products?  <input type="checkbox"/> Yes (2 pts.) <input type="checkbox"/> No (0pt)</p> <hr/> <p>5. Do you have strong negative reactions to caffeine or caffeine containing products?  <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0pt) <input type="checkbox"/> Don't know (0 pt)</p>	<p>11. Do you have an adverse or allergic reaction when you consume sulfite containing foods such wine, dried fruit, salad bar vegetables, etc?  <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0pt) <input type="checkbox"/> Don't know (0 pt)</p> <hr/> <p><b>GRAND TOTAL</b> <span style="float: right;"><b>TOTAL</b> _____</span></p>
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**III. Alkalizing Assessment**

<p>1. Do you have a history or currently have kidney dysfunction?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been diagnosed with a condition known as hyperkalemia?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>3. Are you currently on diuretics or blood pressure medication?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Note: Prescribe non- alkalizing nutrients if patient answered yes to any part of this section.</p>
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**OVERALL SCORE TABULATION**

See doctor brochure for protocol suggestions.

MSQ score: \_\_\_\_\_ (High >50; Moderate 15-49; Low <14)  
 XTT score: \_\_\_\_\_ (High >10; Moderate 5-9; Low <4)  
 Urinary pH: \_\_\_\_\_

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/ immune / allergic gastrointestinal dysfunction, oxidative stress, hormonal / neuro-transmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet and/or nutraceuticals.