Ford's
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FAMILY PHARMACY & WELLNESS CENTRE

Metabolic Detoxification Questionnaire

Name: _____ Age: _____ Birth Date: _____
day month year

Street Address: _____

City: _____ Prov: _____Postal Code: _____

E-mail address: _____ Medicare # _____

Home Phone #: _____ Work Phone #: _____

Rate each of the following symptoms based on your typical health over the **specified time of your choice**: ☐ past month ☐ past week ☐ past 48 hours

0 – never or almost never have the symptom **1** – occasionally have it, effect is not severe
2 – occasionally have it, effect is severe **3** – frequently have it, effect is not severe **4** – frequently have it, effect is severe

Medical Symptoms Questionnaire

HEAD	_____	headaches	
	_____	faintness	
	_____	dizziness	
	_____	insomnia	TOTAL _____
EYES	_____	watery or itchy eyes	
	_____	swollen, reddened or sticky eyelids	
	_____	bags or dark circles under eyes	
	_____	blurred or tunnel vision	TOTAL _____
EARS	_____	itchy ears	
	_____	earaches, ear infections	
	_____	drainage from ear	
	_____	ringing in ears, hearing loss	TOTAL _____
NOSE	_____	stuffy nose	
	_____	sinus problems	
	_____	hay fever	
	_____	insomnia	
	_____	sneezing attacks	
	_____	excessive mucus formation	TOTAL _____

MOUTH/	_____	chronic coughing	
THROAT	_____	gagging, frequent need to clear throat	
	_____	sore throat, hoarseness, loss of voice	
	_____	swollen or discoloured tongue, gums, lips	
	_____	canker sores	TOTAL _____
SKIN	_____	acne	
	_____	hives, rashes, dry skin	
	_____	hair loss	
	_____	flushing, hot flashes	
	_____	excessive sweating	TOTAL _____
HEART	_____	chest pain	
	_____	irregular or skipped heartbeat	
	_____	rapid or pounding heartbeat	TOTAL _____
LUNGS	_____	chest congestion	
	_____	asthma, bronchitis	
	_____	shortness of breath	
	_____	difficulty breathing	TOTAL _____
DIGESTIVE	_____	nausea, vomiting	
TRACT	_____	diarrhea	
	_____	constipation	
	_____	bloated feeling	
	_____	belching, passing gas	
	_____	heartburn	
	_____	intestinal/stomach pain	TOTAL _____
JOINTS /	_____	pain or aches in joints	
MUSCLE	_____	arthritis	
	_____	stiffness or limitation of movement	
	_____	feeling of weakness or tiredness	
	_____	pain or aches in muscles	TOTAL _____

WEIGHT	_____	binge eating / drinking	
	_____	craving certain foods	
	_____	excessive weight	
	_____	water retention	
	_____	underweight	
	_____	compulsive eating	TOTAL _____
ENERGY /	_____	fatigue, sluggishness	
ACTIVITY	_____	apathy, lethargy	
	_____	hyperactivity	
	_____	restlessness	TOTAL _____
MIND	_____	poor memory	
	_____	confusion, poor comprehension	
	_____	difficulty in making decisions	
	_____	stuttering or stammering	
	_____	slurred speech	
	_____	learning disabilities	
	_____	poor concentration	
	_____	poor physical coordination	TOTAL _____
EMOTIONS	_____	mood swings	
	_____	anxiety, fear, nervousness	
	_____	anger, irritability, aggressiveness	
	_____	depression	TOTAL _____
OTHER	_____	frequent illness	
	_____	frequent or urgent urination	
	_____	genital itch or discharge	TOTAL _____

GRAND TOTAL TOTAL _____