Metabolic Clearing Therapy - initial testing scale

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THIS IS A USEFUL SELF ASSESEMENT OF ONE'S DETOXIFICATION FUNCTION BASED ON SYMPTOMS. A SCORE OF 50 OR MORE OR A SCORE OF 10 OR MORE IN ANY 1 SECTION INDICATES THE NEED TO UP-REGULATE YOUR DETOXIFICATION FUNCTION.

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

POINT SCALE:

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

Digestive Tract:

Total:

_____ nausea or vomiting
_____ diarrhea
_____ constipation
_____ bloated feeling
_____ belching or passing gas
_____ heartburn
_____ intestinal/stomach pain

Ears:

Total:

_____ itchy ears
_____ earaches, ear infections
_____ drainage from ear
_____ ringing in ears, hearing loss

Emotions:

Total:

_____ mood swings
_____ anxiety, fear or nervousness
_____ anger, irritability or aggressiveness
_____ depression

Energy/Activity:

Total:

_____ fatigue, sluggishness
_____ apathy, lethargy
_____ hyperactivity
_____ restlessness

Eyes:

Total:

_____ watery or itchy eyes
_____ swollen, reddened or sticky eyelids
_____ bags or dark circles under eyes
_____ blurred or tunnel vision
(does not include near or far sightedness)

Head:

Total:

_____ headaches
_____ faintness
_____ dizziness
_____ insomnia

Heart:

Total:

_____ irregular or skipped heartbeat
_____ rapid or pounding heartbeat
_____ chest pain

Joints/Muscles:

Total:

_____ pain or aches in joints
_____ arthritis
_____ stiffness or limitation of movement
_____ pain or aches in muscles
_____ feeling of weakness or tiredness

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Lungs:

Total:

_____ chest congestion
_____ asthma, bronchitis
_____ shortness of breath
_____ difficulty breathing

Mind:

Total:

_____ poor memory
_____ confusion, poor comprehension
_____ poor concentration
_____ poor physical coordination
_____ difficulty in making decisions
_____ stuttering or stammering
_____ slurred speech
_____ learning disabilities

Mouth/Throat:

Total:

_____ chronic coughing
_____ gagging, frequent need to clear throat
_____ sore throat, hoarseness, loss of voice
_____ swollen or discolored tongue, gums of lips
_____ canker sores

Nose:

Total:

_____ stuffy nose
_____ sinus problems
_____ hay fever
_____ sneezing attacks
_____ excessive mucus formation

Skin:

Total:

_____ acne
_____ hives, rashes, or dry skin
_____ hair loss
_____ flushing or hot flashes
_____ excessive sweating

Weight:

Total:

_____ binge eating/drinking
_____ craving certain foods
_____ excessive weight
_____ compulsive eating
_____ water retention
_____ underweight

Other:

Total:

_____ frequent illness
_____ frequent or urgent urination
_____ genital itch or discharge

Metabolic Clearing Grand total:

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
☐ Yes (1 pt)
If yes, how many are you currently taking?
_____(1 pt each)
☐ No (0 pt)

2. Do you commonly experience "brain fog," fatigue, or drowsiness?
☐ Yes (1 pt) ☐ No (0 pt)

3. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
☐ Yes (1 pt) ☐ No (0 pt) ☐ Don't know (0 pt)

4. Are you presently taking one or more of the following over-the-counter drugs?
☐ Cimetidine (2 pts)
☐ Acetaminophen (2 pts)
☐ Estradiol (2 pts)

5. Do you feel ill after you consume even small amounts of alcohol?
☐ Yes (1 pt) ☐ No (0 pt) ☐ Don't know (0 pt)

6. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
☐ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts)
☐ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts)
☐ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts)
☐ Experience no side effects, drug(s) is (are) usually (0 pts)

7. Do you have a personal history of
☐ Environmental and/or chemical sensitivities (5 pts)
☐ Chronic fatigue syndrome (5 pts)
☐ Multiple chemical sensitivity (5 pts)
☐ Fibromyalgia (3 pts)
☐ Parkinson's type symptoms (3 pts)
☐ Alcohol or chemical dependence (2 pts)
☐ Asthma (1 pt)

8. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
☐ Yes (1 pt) ☐ No (0 pt)

9. Do you currently use or within the last 6 months had you regularly used tobacco products?
☐ Yes (2 pts) ☐ No (0 pt)

10. Do you have an adverse or allergic reaction when you consume sulfite-containing foods such as wine, dried fruit, salad bar vegetables, etc?
☐ Yes (1 pt) ☐ No (0 pt) ☐ Don't know (0 pt)

11. Do you have strong negative reactions to caffeine or caffeine containing products?
☐ Yes (1 pt) ☐ No (0 pt) ☐ Don't know (0 pt)

III. Alkalizing Assessment

1. Do you have a history or currently have kidney dysfunction?
☐ Yes ☐ No

2. Are you currently on diuretics or blood pressure medicine?
☐ Yes ☐ No

3. Have you ever been diagnosed with a condition known as hyperkalemia?
☐ Yes ☐ No

NOTE: Prescribe non-alkalizing nutrients if patient answered yes to any part of this section.

OVERALL SCORE TABULATION (for practitioner use only)

See doctor brochure for protocol suggestions.

Metabolic Clearing Grand Total: ____________ (High >50; moderate 15-49; Low <14)

Xenobiotic Tolerability Test Score: ____________ (High >10; moderate 5-9; Low <4)

Urinary pH ____________

Note: Patients with high MCGT 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 dysfuntion, oxidative stress, hormonal/neuro-transmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.