FAB - Detoxification Questionnaire

Name: _____ Date: _____

Rate each of the following symptoms based on the past 30 days using the following scoring scale: 0 = Never or rarely had the symptoms
1 = Have had temporary, mild symptoms 2 = Have had temporary, severe symptoms
3 = Have had regular, mild symptoms 4 = Have had regular, severe symptoms

Where there are more options, underline the one that best fits.
Add up each group to get a subtotal, then add the subtotals for a grand total. If any subtotal shows more than 10 points or if the total is over 50 points, you may need to undergo a detoxification program. Based on your test results, your therapist can tailor a nutritional supplement program and guide you through an effective and scientifically proven detoxification program. The therapist will also help you with an individually designed rebuilding program to optimize your health.

Energy/activity

__ fatigue, laziness
__ passivity, apathy
__ hyperactivity
__ restlessness
Amount__

Brain
__ poor memory
__ confusion, poor comprehension
__ poor ability to concentrate
__ poor physical coordination
__ difficulty to take decision
__ stuttering
__ unclear speech
__ learning problems
Total __

Heart
__ irregular or missed heartbeat
__ fast or pounding heartbeats
__ chest pain
Sum __

Skin
__ acne
__ rash, eczema, dry skin, itching
__ hair loss
__ redness, swelling
__ exaggerated sweating
Total __

Head

__ headache
__ dullness
__ dizziness clear your throat
__ sleep disturbances
Total __

Total __

Emotions
__ mood swings
__ worry, fear, nervousness
__ anger, irritation, aggressiveness
__ low mood, depression
Total____ formation

Joints and muscles
__ pain or aches in leads
__ joint inflammation, arthritis
__ stiffness or limited movement-ability

__ pain or ache in muscles
__ feeling weak or fatigue
Total__ __ underweight

Lungs
__ mucus formation
__ asthma, bronchitis
__ shortness of breath
__ breathing difficulties Total__

Digestion
__ nausea, vomiting
__ diarrhea, loose stools
__ constipation
__ feeling bloated __ itchy ears
__ belching, gas __ painful ears, otitis
__ heartburn
__ intestinal/stomach
Total __

Mouth/throat
__ cough
__ retching, frequent need of to
Total__
__ sore throat, hoarseness, difficulty to talk
__ swollen or discolored tongue, gums or lips

Nose

__ nasal congestion
__ sinus problems
__ hay fever
__ nose attacks
__ excessive mucus
Total __

Weight
__ excessive eating and/or drinking
__ request for special food
__ overweight

__ compulsive eating
__ fluid retention
Total __

Eyes

__ watery or itchy eyes
__ swollen, red or stinging eyelid
__ bags or dark circles underneath the eyes
__ blurred vision or tunnel vision
Total __

Ears

__ runny ears
__ ringing in the ears, poor hearing
Total __

Miscellaneous
__ need to urinate frequently
__ vaginal itching/discharge, anal itching

grand total __