Name & Surname: _____ **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?	☐	☐	☐	☐	☐
How often do you eat non-organic foods?	☐	☐	☐	☐	☐
Do you eat processed meat, or fatty meat such as ham, salami or sausages?	☐	☐	☐	☐	☐
Do you drink alcohol?	☐	☐	☐	☐	☐
Do you drink more than four alcoholic drinks in one sitting?	☐	☐	☐	☐	☐
Do you use 'social' or 'recreational' drugs?	☐	☐	☐	☐	☐
Does your diet contain soft drink and/or junk food (e.g. chips, chocolate, biscuits, lollies, cakes, cookies)?	☐	☐	☐	☐	☐
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)?	☐	☐	☐	☐	☐
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)?	N ☐				Y ☐
Are you, or have you been, exposed to heavy traffic, exhaust fumes and pollution?	☐	☐	☐	☐	☐
Do you use synthetic cleaning products at home (e.g. disinfectants, detergents, bleach, polishes and similar products)?	☐	☐	☐	☐	☐
Are you regularly exposed to nail polish, hair dyes and similar products?	☐	☐	☐	☐	☐
Do you suffer from fatigue?	☐	☐	☐	☐	☐
Do you suffer from headaches or migraines?	☐	☐	☐	☐	☐
Do you currently suffer with any skin conditions (e.g. eczema, acne and/or rosacea)?	N ☐				Y ☐
Do you suffer from allergies or asthma?	☐	☐	☐	☐	☐
Do you experience PMS, irregular periods or heavy periods?	N ☐				Y ☐
Have you lost/are you trying to lose a significant amount of weight?	N ☐				Y ☐
Do you have trouble losing weight or regain lost weight quickly?	N ☐				Y ☐
Do you pass stools that are slightly loose or not well-formed?	☐	☐	☐	☐	☐
Do you feel a sensation of incomplete emptying of the bowel?	☐	☐	☐	☐	☐
Is there mucus or blood in your bowel motion?	☐	☐	☐	☐	☐
Have you been on a course of antibiotics in the last 12 months?	N ☐				Y ☐
Do you take pharmaceutical anti-inflammatory or pain relief medicines?	N ☐				Y ☐
Are you taking or have you previously been on proton pump inhibitors?	N ☐				Y ☐
Are you or your partner planning on becoming pregnant in the next six months?	N ☐				Y ☐
Have you done a Practitioner guided detoxification in the past six months?	Y ☐				N ☐
Total					
			Section 1 Total		

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SECTION 2	0	1	2	3	4
Do you experience abdominal bloating?	☐	☐	☐	☐	☐
Do you experience excessive burping?	☐	☐	☐	☐	☐
Do you suffer from abdominal pain or discomfort?	☐	☐	☐	☐	☐
Do you suffer from excessive flatulence, wind or foul smelling wind?	☐	☐	☐	☐	☐
Do you experience nausea or loss of appetite?	☐	☐	☐	☐	☐
Do you suffer from heartburn, indigestion or reflux/acid regurgitation?	☐	☐	☐	☐	☐
Do you get diarrhoea (loose and/or frequent stool)?	☐	☐	☐	☐	☐
Do you experience constipation (less than one bowel motion a day)?	☐	☐	☐	☐	☐
Have you been diagnosed with irritable bowel syndrome or inflammatory bowel disease?	N ☐				Y ☐
Do you suffer from oral or vaginal thrush (candida)?	N ☐				Y ☐
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?	☐	☐	☐	☐	☐
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.)?	N ☐				Y ☐
Do you smoke? Or have you previously smoked regularly in the last four years?	☐	☐	☐	☐	☐
Do you have a new (less than one year old) car, furniture or carpets; or have you ever renovated an old house?	N ☐				Y ☐
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?	☐	☐	☐	☐	☐
Do health complaints reappear or worsen during weight loss?	N ☐				Y ☐
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?	☐	☐	☐	☐	☐
Do you get numbness, tingling or weakness in parts of your body?	☐	☐	☐	☐	☐
Do you eat large deep-sea predator fish such as tuna or swordfish?	☐	☐	☐	☐	☐
Do you have, or have you ever had, mercury amalgam dental fillings (silver/grey, not white)?	N ☐				Y ☐
Total					
		Section 3 Total			

OUTCOMES	SECTION TOTALS	
If total score above 35 – Foundational Detox Program	Section 1	
If total score above 35 and section 2 score above 12 – Gut Detox Program	Section 2	
If total score above 35 and section 3 score above 12 – Advanced Detox Program	Section 3	
	Total Score	

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