

II. Xenobiotic Tolerability Test (XTT)

<p>1. Are you presently using prescription drugs? <input type="checkbox"/> Yes (1 pt.) If yes, how many are you currently taking? _____ (1 pt. each) <input type="checkbox"/> No (0 pt.)</p> <hr/> <p>2. Are you presently taking one or more of the following over-the-counter drugs? <input type="checkbox"/> Cimetidine (2 pts.) <input type="checkbox"/> Acetaminophen (2 pts.) <input type="checkbox"/> Estradiol (2 pts.)</p> <hr/> <p>3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them: <input type="checkbox"/> Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.) <input type="checkbox"/> Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.) <input type="checkbox"/> Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.) <input type="checkbox"/> Experience no side effects, drug(s) is (are) usually efficacious (0 pt.)</p> <hr/> <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 (0 pt.)</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 (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p>	<p>6. Do you commonly experience "brain fog," fatigue, or drowsiness? _____</p> <hr/> <p>7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors? <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p> <hr/> <p>8. Do you feel ill after you consume even small amounts of alcohol? <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p> <hr/> <p>10. Do you have a personal history of <input type="checkbox"/> Environmental and/or chemical sensitivities (5 pts.) <input type="checkbox"/> Chronic fatigue syndrome (5 pts.) <input type="checkbox"/> Multiple chemical sensitivity (5 pts.) <input type="checkbox"/> Fibromyalgia (3 pts.) <input type="checkbox"/> Parkinson's type symptoms (3 pts.) <input type="checkbox"/> Alcohol or chemical dependence (2 pts.) <input type="checkbox"/> Asthma (1 pt.)</p> <hr/> <p>11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents? <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.)</p> <hr/> <p>12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc? <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p> <p>GRAND TOTAL: _____</p>
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III. Alkalinizing 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-alkalinizing nutrients if patient answered yes to any part of this section.</p>
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For Practitioner Use Only:

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.