Environmental and Detoxification Assessment

Do you have any known adverse food reactions or sensitivities? □ Yes □ No
If yes, describe symptoms: _____
Do you have any food allergies? □ Yes List all: _____
□ No
Do you have an adverse reaction to caffeine? □ Yes □ No
When you drink caffeine do you feel: □ Irritable or Wired □ Aches & Pains
Do you adversely react to **(Check all that apply):**

- □ Monosodium glutamate (MSG)
- □ Aspartame (Nutraweet)
- □ Caffeine
- □ Bananas
- □ Garlic
- □ Onion
- □ Cheese
- □ Citrus Foods
- □ Chocolate
- □ Preservatives (ex. Sodium benzoate)
- □ Red Wine
- □ Alcohol
- □ Sulfite containing foods (wine, dried fruit, salad bars)
- □ Other: _____

Which of these significantly affect you? **(Check all that apply):**

- □ Cigarette Smoke
- □ Perfumes/colognes
- □ Auto Exhaust Fumes
- □ Other: _____

In your work or home environment, are you exposed to:

- □ Chemicals
- □ Electromagnetic Radiation
- □ Mold
- □ Other: _____

Have you ever turned yellow (jaundiced)? □ Yes □ No
Have you ever been told you have Gilbert's syndrome or a liver disorder? □ Yes □ No
Explain: _____
Do you have a known history of significant exposure to any harmful chemicals such as the following:

- □ Herbicides
- □ Pesticides
- □ Insecticides (frequent visits of exterminator)
- □ Organic Solvents
- □ Heavy Metals
- □ Other _____

Chemical Name, Date and Length of Exposure: _____

Do you dry clean your clothes frequently? □ Yes □ No
Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? □ Yes □ No
Do you have any pets or farm animals? □ Yes □ No
Types: _____

Patient Name: _____ Date of Birth: _____