



Hormone Imbalance Assessment

Indicate the symptoms you are experiencing:

0 = None 1 = Mild 2 = Moderate 3 = Severe

WOMEN

Cause	Symptoms		
Low Estradiol	<input type="checkbox"/> Hot Flashes <input type="checkbox"/> Incontinence	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Vaginal Dryness
Estrogen Dominance	<input type="checkbox"/> Bleeding Changes <input type="checkbox"/> Tender Breasts <input type="checkbox"/> Foggy thinking <input type="checkbox"/> Mood swings	<input type="checkbox"/> Uterine Fibroids <input type="checkbox"/> Fibrocystic Breasts <input type="checkbox"/> Tearful	<input type="checkbox"/> Water Retention <input type="checkbox"/> Increased Forgetfulness <input type="checkbox"/> Depressed
Adrenal Fatigue	<input type="checkbox"/> Stress <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Irritable <input type="checkbox"/> Allergies <input type="checkbox"/> Dizzy Spells	<input type="checkbox"/> Morning Fatigue <input type="checkbox"/> Decreased Stamina <input type="checkbox"/> Nervous <input type="checkbox"/> Headaches	<input type="checkbox"/> Evening Fatigue <input type="checkbox"/> Anxiety <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Sugar Cravings
Thyroid	<input type="checkbox"/> Cold Body Temperature <input type="checkbox"/> Nails Breaking or Brittle <input type="checkbox"/> Rapid Heart Beat <input type="checkbox"/> Goiter (thick band around front of neck)	<input type="checkbox"/> Hoarseness <input type="checkbox"/> Constipation <input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Hair Dry or Brittle <input type="checkbox"/> Slow Pulse Rate <input type="checkbox"/> Infertility Problems
Metabolic Syndrome/ High Androgens	<input type="checkbox"/> Acne <input type="checkbox"/> Weight Gain - Hips <input type="checkbox"/> Increase Facial / Body Hair	<input type="checkbox"/> Elevated Triglycerides <input type="checkbox"/> Weight Gain - Waist	<input type="checkbox"/> Scalp Hair Loss <input type="checkbox"/> High Cholesterol
Low Androgens	<input type="checkbox"/> Decreased Libido <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Bone Loss	<input type="checkbox"/> Decreased Muscle Size <input type="checkbox"/> Rapid Aging	<input type="checkbox"/> Thinning skin <input type="checkbox"/> Aches and Pains

Your height: _____

Your weight: _____

MEN

Cause	Symptoms		
Estrogen Dominance	<input type="checkbox"/> Decreased Urine Flow <input type="checkbox"/> Weight Gain- Waist	<input type="checkbox"/> Increased Urinary Urge <input type="checkbox"/> Weight Gain-Chest / Hips	<input type="checkbox"/> Water retention
Adrenals	<input type="checkbox"/> Burn Out Feeling <input type="checkbox"/> Stress <input type="checkbox"/> Depression <input type="checkbox"/> Irritable <input type="checkbox"/> Sugar Cravings	<input type="checkbox"/> Morning Fatigue <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Mental Fatigue <input type="checkbox"/> Nervous <input type="checkbox"/> Dizzy Spells	<input type="checkbox"/> Evening Fatigue <input type="checkbox"/> Apathy <input type="checkbox"/> Anxious <input type="checkbox"/> Headaches
Thyroid	<input type="checkbox"/> Cold Body Temperature <input type="checkbox"/> Nails Breaking or Brittle <input type="checkbox"/> Rapid Heart Beat <input type="checkbox"/> Goiter (thick band around front of neck)	<input type="checkbox"/> Hoarseness <input type="checkbox"/> Constipation <input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Hair Dry or Brittle <input type="checkbox"/> Slow Pulse Rate <input type="checkbox"/> Infertility Problems
Metabolic Syndrome/ High Androgens	<input type="checkbox"/> Decreased libido <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Decreased Muscle Size <input type="checkbox"/> Sore Muscles <input type="checkbox"/> Bone Loss <input type="checkbox"/> Decreased Stamina	<input type="checkbox"/> Decreased erections <input type="checkbox"/> Elevated Triglycerides <input type="checkbox"/> Increased Forgetfulness <input type="checkbox"/> Increased Joint Pain <input type="checkbox"/> Rapid Aging <input type="checkbox"/> Night Sweats	<input type="checkbox"/> Ringing in ears <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Decreased Mental Sharpness <input type="checkbox"/> Neck or Back Pain <input type="checkbox"/> Thinning Skin
Thyroid / Other	<input type="checkbox"/> Cold Body Temperature <input type="checkbox"/> Nails Breaking or Brittle <input type="checkbox"/> Rapid Heart Beat <input type="checkbox"/> Allergies	<input type="checkbox"/> Hoarseness <input type="checkbox"/> Constipation <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Goiter (thick band around the neck)	<input type="checkbox"/> Hair Dry or Brittle <input type="checkbox"/> Slow Pulse Rate <input type="checkbox"/> Infertility Problems

Your height: _____

Your weight: _____

*This questionnaire will help you assess your health status. It is not meant as a replacement for a physician's care.
The answers will help you focus your attention on specific areas of need.*