

INTAKE FORM

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email: _____
SSN# _____ Date of Birth: ___/___/___ Age: _____
Gender: Male Female
Height: _____ Weight: _____

Employer: _____

Primary Insurance Information

Primary Address: _____
Primary ID Number: _____
Primary Group ID: _____

Primary Cardholder Information

Name: _____
Address: _____
City: _____ State: _____ Zip: _____

Secondary Insurance Information

Secondary Address: _____
Secondary ID Number: _____
Secondary Group ID: _____

ASSIGNMENT AND RELEASE.

I, undersigned and verify that, to the best of my knowledge, the information above is correct. I assign directly to Active Life Institute all insurance benefits. If any, otherwise payable services are rendered, I understand that I am financially responsible for changes whether or not paid by insurance. **By signing this form you fully understand that Active Life Institute is not a participant of Medicaid or Medicare and will not provide services to Medicaid or Medicare patients at this time.** I hereby authorize release of information necessary to secure that payment of benefits. I authorize the use of this signature in all insurance submissions.

Signature

Relationship

Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have been offered or have received a copy of the Privacy Notice.

Patient Name: _____ Date: _____

Signature of Patient: _____ Date: _____

Signature of Representative: _____ Date: _____

Relationship to Patient: _____

MESSAGE AUTHORIZATION

Patient Name: _____ Date of Birth: ___/___/___

Please Circle Yes or No for the following questions:

Do you give the staff at Active Life Institute permission to leave messages on your voice mail?

YES NO

Do you give the staff at Active Life Institute permission to discuss your health care issues with your spouse or other designated person?

YES NO

If yes, please list spouse/designated individuals and phone contacts:

Signature: _____ Date: _____

Witnessed by: _____ Date: _____

_____ Date: _____

I, _____, hereby authorize and request:

Healthcare Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

To provide records to the office personnel at the Seneca/Naperville Office of:

Active Life Institute

409 S. Main Street Seneca, IL 61360

304 Ogden Ave Naperville, IL 60563

- The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records.

To be disclosed, the following items must be checked:

- Mental Health Treatment Records
- Alcoholism Treatment Records
- Drug Abuse Treatment Records
- HIV/Acquired Immune Deficiency Syndrome (AIDS) Records
- X-Ray Reports
- Operative Notes
- Other _____

I authorize you to release all of the information requested, which may include information relating to psychiatric treatment/testing, or treatment relating to drug or alcohol abuse, or information concerning AIDS antibody testing, if any, including the test results thereof, without limitations placed on dates, history of illness, and/or diagnostic testing.

REASON FOR RELEASE: _____

(Example: moving, second opinion, personal)

The information to be released is confidential. Further disclosure by the receiving party is strictly prohibited except as specifically authorized.

I understand that I may revoke this consent at any time, except if action has already been taken in regards to this request. This consent automatically expires upon compliance of this request and will not serve for any future request.

SIGNATURES: _____

Patient

Date Signed

Patient

Date Signed

LIFESTYLE INFORMATION:

	Do you use? (<i>Yes or No</i>)	If Yes, how often and how much?
Tobacco (<i>Chew, Smoke, Snuff</i>)	_____	_____
Alcohol	_____	_____
Caffeine (<i>Cola, Tea, Coffee</i>)	_____	_____
Artificial Sweeteners	_____	_____

Do you snore or stop breathing when sleeping? Yes No

EXERCISE: Do you exercise regularly? Yes No
If Yes, describe what you do and how often:

STRESS MANAGEMENT:

Do you practice any stress management techniques? Yes No
If Yes, describe what you do and how often:

DIET: Describe your meals that you consume on a typical day (*For example, What did you eat yesterday?*).

1st Meal: _____ 2nd Meal: _____ 3rd Meal: _____

4th Meal: _____ 5th Meal: _____ Other: _____

DOCTORS:

Doctor's Name: _____
Location: _____

Doctor's Name: _____
Location: _____

Doctor's Name: _____
Location: _____

EMPLOYMENT HISTORY: Where are you presently employed?

Do you or have you ever worked 2nd or 3rd shift? Yes No
Have you any military experience? Yes No
Have you ever worked in law enforcement? Yes No
Have you ever worked in health care? Yes No

ALLERGIES: Please list all allergies to medications (if any) and what reactions have occurred (if any):

MEDICATIONS: Please list any prescription medication you currently take, including samples.

<u>Medication Name</u>	<u>Dose</u>	<u>Number of times per day</u>	<u>Doctor</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____

HERBAL/SUPPLEMENTS: Please list any vitamins, herbs, enzymes, protein supplements, pro-hormones or any other supplements.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

PAST MEDICAL HISTORY AND CURRENT MEDICAL CONDITIONS: Please check all that apply to you.

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Head Trauma |
| <input type="checkbox"/> Hormone Related Issues | <input type="checkbox"/> Headaches | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Abnormal PAP | <input type="checkbox"/> Prader Willi Syndrome |
| <input type="checkbox"/> Diagnosed Obesity | <input type="checkbox"/> Elevated PSA Test | |

List any other medical conditions that you currently receive treatment for (*medical, chiropractor, physical therapist, etc.*).

BODY IMAGE:

Are you comfortable with your current weight and size?

Yes No

Do you struggle to lose weight?

Yes No

GOALS:

What do you hope to accomplish at Active Life Institute?

- 1. _____
- 2. _____
- 3. _____
- 4. _____

How did you hear about Active Life Institute?

SF-36 Questionnaire

1. In general would you say your health is:

- Excellent
- Good
- Fair
- Poor

2. Compared to one year ago, how would you rate your health in general now?

- Much better now than one year ago
- Somewhat better than one year ago
- About the same as one year ago
- Much worse than one year ago

3. Does your health now limit you in activities you might do during a typical day? If so, how much?

- Yes, Limited a lot
- Yes, Limited a little
- No, Not limited at all

4. During the past 4 weeks have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

(Please circle yes or no)

- a. Cut down the amount of time you spent on work or other activities.
 Yes No
- b. Accomplished less than you would like.
 Yes No
- c. Were limited in the kind of work or other activities.
 Yes No
- d. Had difficulty performing at work or other activities *(for example, it took extra effort)*.
 Yes No

5. During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)? *(Please circle yes or no)*

- a. Cut down the amount of time you spent on work or other activities.
 Yes No
- b. Accomplished less than you would like.
 Yes No
- c. Were limited in the kind of work or other activities.
 Yes No
- d. Had difficulty performing at work or other activities *(for example, it took extra effort)*.
 Yes No

6. During the past 4 weeks to what extent has your physical health, emotional problems interfered with your normal social activities with family, friends, neighbors or groups?

- Not at all
- Slightly
- Moderately
- Severe
- Very severe

7. How much bodily pain have you had during the past 4 weeks?

- None
- Very mild
- Mild
- Moderate
- Severe
- Very severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks: (Please check one)

a. Did you feel full of pep?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

b. Have you been a nervous person?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

c. Have you felt so down in the dumps that nothing could cheer you up?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

d. Have you felt calm and peaceful?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

e. Did you have a lot of energy?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

f. Have you felt downhearted or blue?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

g. Did you feel worn out?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

h. Have you been a happy person?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

i. Did you feel tired?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

10. During the past 4 weeks how much of the time has your physical health or emotional problems interfered with you social activities (like visiting either friends, relatives, ect.)?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

11. How TRUE or FALSE is each of the following statements for you?

a. I seem to get sick easier than other people

- Definitely true
- Mostly true
- Don't know
- Mostly false
- Definitely false

c. I expect my health to get worse

- Definitely true
- Mostly true
- Don't know
- Mostly false
- Definitely false

b. I am as healthy as anybody I know

- Definitely true
- Mostly true
- Don't know
- Mostly false
- Definitely false

d. My health is excellent

- Definitely true
- Mostly true
- Don't know
- Mostly false
- Definitely false

Holmes Rahe Social Readjustment Rating Scale

Adult Stress Please check the items that are relevant in the past 6 months.

Death of a Spouse	100	<input type="checkbox"/>	Change in responsibilities at work	25	<input type="checkbox"/>
Divorce	60	<input type="checkbox"/>	Trouble with in-laws, or with children	25	<input type="checkbox"/>
Menopause	60	<input type="checkbox"/>	Outstanding personal achievement	25	<input type="checkbox"/>
Separation from living partner	60	<input type="checkbox"/>	Spouse begins or stops work	20	<input type="checkbox"/>
Jail term or probation	60	<input type="checkbox"/>	Begin or end school	20	<input type="checkbox"/>
Death of close family member other than spouse	60	<input type="checkbox"/>	Change in living conditions (<i>visitors in the home, change in roommates, remodeling house</i>)	20	<input type="checkbox"/>
Serious personal injury or illness	45	<input type="checkbox"/>	Change in personal habits (<i>diet, exercise, smoking, etc.</i>)	20	<input type="checkbox"/>
Marriage or establishing life partnership	45	<input type="checkbox"/>	Chronic Allergies	20	<input type="checkbox"/>
Fired at work	45	<input type="checkbox"/>	Trouble with boss	20	<input type="checkbox"/>
Marital or relationship life partnership	40	<input type="checkbox"/>	Change in work hours or conditions	15	<input type="checkbox"/>
Retirement	40	<input type="checkbox"/>	Moving to new residence	15	<input type="checkbox"/>
Change in health of immediate family member	40	<input type="checkbox"/>	Presently in pre-menstrual period	15	<input type="checkbox"/>
Work more than 40 hours per week	35	<input type="checkbox"/>	Change in School	15	<input type="checkbox"/>
Pregnancy or causing pregnancy	35	<input type="checkbox"/>	Change in social activities (<i>more or less than before</i>)	15	<input type="checkbox"/>
Sex difficulties	35	<input type="checkbox"/>	Minor financial loan	10	<input type="checkbox"/>
Gain of new family member	35	<input type="checkbox"/>	Change in frequency of family get-togethers	10	<input type="checkbox"/>
Business or work role change	35	<input type="checkbox"/>	Vacation	10	<input type="checkbox"/>
Change in financial state	35	<input type="checkbox"/>	Presently in winter holiday season	10	<input type="checkbox"/>
Death of a close friend (<i>not a family member</i>)	30	<input type="checkbox"/>	Minor violation of the law	5	<input type="checkbox"/>
Mortgage or loan for a mortgage or loan	25	<input type="checkbox"/>			
Foreclosure of mortgage or loan	25	<input type="checkbox"/>			
Sleep less than 8 hours per night	25	<input type="checkbox"/>	Total		0

Adult Growth Hormone Deficiency Assessment

QoL-AGHDA

Instructions: Indicate whether each of the following statements below applies to you:

	Yes	No
I have to struggle to finish jobs.....	<input type="checkbox"/>	<input type="checkbox"/>
I feel a strong need to sleep during the day	<input type="checkbox"/>	<input type="checkbox"/>
I often feel lonely even when I am with other people.....	<input type="checkbox"/>	<input type="checkbox"/>
I have to read things several times before they sink in	<input type="checkbox"/>	<input type="checkbox"/>
It is difficult for me to make friends	<input type="checkbox"/>	<input type="checkbox"/>
It takes a lot of effort for me to do simple tasks	<input type="checkbox"/>	<input type="checkbox"/>
I have difficulty controlling my emotions	<input type="checkbox"/>	<input type="checkbox"/>
I often lose track of what I want to say	<input type="checkbox"/>	<input type="checkbox"/>
I lack confidence	<input type="checkbox"/>	<input type="checkbox"/>
I have to push myself to do things.....	<input type="checkbox"/>	<input type="checkbox"/>
I often feel very tense.....	<input type="checkbox"/>	<input type="checkbox"/>
I feel as if I let people down.....	<input type="checkbox"/>	<input type="checkbox"/>
I find it hard to mix with people.....	<input type="checkbox"/>	<input type="checkbox"/>
I feel worn out even when I'm not doing anything	<input type="checkbox"/>	<input type="checkbox"/>
There are times I feel very low	<input type="checkbox"/>	<input type="checkbox"/>
I avoid responsibility if possible	<input type="checkbox"/>	<input type="checkbox"/>
I avoid mixing with people I don't know well	<input type="checkbox"/>	<input type="checkbox"/>
I feel as if I am a burden to people.....	<input type="checkbox"/>	<input type="checkbox"/>
I often forget what people said to me	<input type="checkbox"/>	<input type="checkbox"/>
I find it difficult to plan ahead	<input type="checkbox"/>	<input type="checkbox"/>
I am easily irritated by other people	<input type="checkbox"/>	<input type="checkbox"/>
I often feel too tired to do the things I ought to do.....	<input type="checkbox"/>	<input type="checkbox"/>
I have to force myself to do things that need doing	<input type="checkbox"/>	<input type="checkbox"/>
I often have to force myself to stay awake	<input type="checkbox"/>	<input type="checkbox"/>
My memory lets me down	<input type="checkbox"/>	<input type="checkbox"/>

Thyroid Function and Evaluation Tool

Name: _____ Sex: _____ Date: ____/____/____ Problem: _____

Please score with "0" meaning "Not at All" and "5" meaning "Most Certainly".

Do you feel exhausted from morning to night?	0	_____
Do you have trouble getting up in the morning?	0	_____
Do you have morning stiffness?	0	_____
Do you have dry skin, brittle nails, or hair?	0	_____
Do you have cold hands and feet?	0	_____
Is your short term memory deteriorating?	0	_____
Do you have trouble working under pressure?	0	_____
Do you have trouble losing weight no matter what you do?	0	_____
Are you depressed?	0	_____
Are you constipated?	0	_____
Do your muscles feel weak as if they can't generate energy?	0	_____
Is your cholesterol over 200?	0	_____
Do you have or did you have PMS or Menstrual difficulty?	<input type="radio"/> Yes	<input type="radio"/> No
Have you ever had trouble with fertility?	<input type="radio"/> Yes	<input type="radio"/> No
Is your first morning under arm body temperature less than 97.8°F?	<input type="radio"/> Yes	<input type="radio"/> No
Do you use any sort of thyroid supplementation?	<input type="radio"/> Yes	<input type="radio"/> No

Natural Hormone Replacement Evaluation

Name: _____ Age: _____ Birth Date: _____
Marital Status: Married Single Divorced Widowed

GENERAL HEALTH

Excellent Good Fair Poor

Have you had your cholesterol checked in the last year? Yes No
If yes, where? _____

Have you had a mammogram? Yes No
If yes, when and where? _____

Have you had a bone dixa scan? Yes No
If yes, when and where? _____

FAMILY HISTORY

Please list any illness that the following members of your family have had:

Mother: _____ Deceased Yes No
Age of death if applicable: _____

Father: _____ Deceased Yes No
Age of death if applicable: _____

Siblings: _____ Deceased Yes No
Age of death if applicable: _____

Children: _____ Deceased Yes No
Age of death if applicable: _____

GYNECOLOGICAL HISTORY

Age of first period: _____ Age of last period: _____

Date of last PAP: _____ Location: _____

Have you ever had an abnormal PAP? Yes No
If yes, please elaborate? _____

Have you undergone any gynecological or urological surgeries? Yes No

Please list: _____

Are you sexually active? Yes No Are you trying to get pregnant? Yes No

Please list any birth control methods. _____

Are your periods regular? Yes No How many days do your periods last? _____
Any abnormality with flow? Yes No Any cramps? Yes No
Any premenstrual symptoms? Yes No Any fluctuations in timing of periods? Yes No
Starting and ending when? _____ Any bleeding between periods? Yes No
Any pelvic pressure of fullness? Yes No

Any unusual vaginal discharge or itching or recurrent urinary tract infections? Yes No
 Please describe: _____

Number of children: _____ Number of pregnancies: _____
 Any abortions or interrupted pregnancies? Yes No

SYMPTOMS REPORT

Please rate the symptoms as this tool will be used to assess appropriate therapy.

Headaches	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Decreased libido	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Anxiety	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Breast Swelling	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Breast Tenderness	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Moodiness	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Foggy or fuzzy thoughts	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Sleep disturbances	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Vaginal Dryness	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Dry hair/skin	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Depression or anxiety	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Hair loss	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Heart palpitations	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Flushing or hot flashes	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Frequent yeast infections	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Painful intercourse	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Irritability	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Weight gain	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Concentrations problems	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Shortness of breath	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Night sweats	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Inability to have orgasms	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Fluid retention	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Breast lumps or fibroids	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Loss of sex drive	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Bleeding abnormalities	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Heat or cold intolerance	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe

Adrenal Health Questionnaire: Section A

1 point for each yes

- | | | |
|--|----|----|
| 1. Do you frequently have low body temperatures? (<98 degrees F) | OY | ON |
| 2. Do you frequently get irritable? | OY | ON |
| 3. Do you have poor memory or concentration? | OY | ON |
| 4. Do you notice palpitations? | OY | ON |
| 5. Do you suffer from allergies or asthma? | OY | ON |
| 6. Do you bruise easily or find your wounds heal slowly? | OY | ON |
| 7. Do you get frequent / chronic infections? | OY | ON |
| 8. Do you have dry, thinning skin? | OY | ON |
| 9. Do you get headaches? | OY | ON |
| 10. Do you have unexplained hair loss? | OY | ON |
| 11. Do you skip meals? | OY | ON |
| 12. Do you exercise more than one time each week? | OY | ON |
| 13. Do you have thyroid problems? | OY | ON |
| 14. Is your energy good all day? | OY | ON |
| 15. Do you need caffeine in the morning or after lunch? | OY | ON |

3 points for each yes

- | | | |
|---|----|----|
| 16. Are you emotionally overstressed? | OY | ON |
| 17. Do you get tenderness across your lower back? | OY | ON |
| 18. Do you suffer from depression or down moods? | OY | ON |
| 19. Do you have low blood pressure? | OY | ON |
| 20. Do you experience a "second wind" (high energy) at bedtime? | OY | ON |
| 21. Do you experience chronic or recurrent inflammation? | OY | ON |
| 22. Do you get light headed when sitting up or standing? | OY | ON |

5 points for each yes

- | | | |
|--|------|----|
| 23. Do you suffer from chronic pain? | OY | ON |
| 24. Do you suffer from low blood sugar / hypoglycemia?
(i.e. headaches, sleepiness, mood swings if skipping meals) | OY | ON |
| 25. Do you suffer from insomnia? | OY* | ON |
| 26. Do you experience symptoms of PMS?
(breast tenderness, abdominal cramping, heavy periods, mood swings) | OY** | ON |
| 27. Are you menopausal or peri menopausal?
(skipped periods, between 45-55 years old, hot flashes, vaginal dryness) | OY** | ON |

If your score >10 you probably have some degree of adrenal exhaustion

If your score >20 it is highly probable you have adrenal exhaustion

If your score > 30 it is nearly certain you have adrenal exhaustion

* If you answered yes to question 25, please also complete **Section B - Insomnia**

** If you answered yes to questions 26 or 27, please also complete **Section C - Female Hormone**

Adrenal Health Questionnaire: Section B - Insomnia

- | | | |
|--|-------------------------|-------------------------|
| 1. Do you experience difficulty falling asleep? | <input type="radio"/> Y | <input type="radio"/> N |
| 2. Does your mind race when you are trying to go to sleep? | <input type="radio"/> Y | <input type="radio"/> N |
| 3. Does it take you more than 20 minutes to fall asleep once lights are off? | <input type="radio"/> Y | <input type="radio"/> N |
| 4. Do you experience a second wind (high energy) at night? | <input type="radio"/> Y | <input type="radio"/> N |
| 5. Do you have trouble staying asleep? | <input type="radio"/> Y | <input type="radio"/> N |
| 6. Do you wake more than once per night? | <input type="radio"/> Y | <input type="radio"/> N |
| 7. Do you have trouble going back to sleep once awakened? | <input type="radio"/> Y | <input type="radio"/> N |
| 8. Do you frequently waken between 2 -3 am? | <input type="radio"/> Y | <input type="radio"/> N |
| 9. Do you experience restless legs when trying to sleep? | <input type="radio"/> Y | <input type="radio"/> N |
| 10. Do you recall your dream? | <input type="radio"/> Y | <input type="radio"/> N |
| 11. Do you have vivid or disturbing nightmares? | <input type="radio"/> Y | <input type="radio"/> N |
| 12. Do you sleep / nap during daylight hours? | <input type="radio"/> Y | <input type="radio"/> N |
| 13. Do you feel groggy or sleepy when you awaken? | <input type="radio"/> Y | <input type="radio"/> N |
| 14. Do your work "third shift" (work nights / sleep days)? | <input type="radio"/> Y | <input type="radio"/> N |
| 15. Are you depressed when weather is cloudy or overcast? | <input type="radio"/> Y | <input type="radio"/> N |
| 16. Are you taking any sleep pills, natural or prescription? | <input type="radio"/> Y | <input type="radio"/> N |
| 17. Do you snore? | <input type="radio"/> Y | <input type="radio"/> N |
| 18. Have you ever been diagnosed with sleep apnea? | <input type="radio"/> Y | <input type="radio"/> N |
| 19. Do you use coffee, caffeine, or other stimulants / medications? | <input type="radio"/> Y | <input type="radio"/> N |
| 20. Do you have children or pets that sleep in your room / bed? | <input type="radio"/> Y | <input type="radio"/> N |
| 21. Do you exercise late in the day? | <input type="radio"/> Y | <input type="radio"/> N |
| 22. Do you eat carbohydrate snacks before bed (cake, cookies, ice cream)? | <input type="radio"/> Y | <input type="radio"/> N |
| 23. Do you eat nothing between dinner and bedtime? | <input type="radio"/> Y | <input type="radio"/> N |
| 24. Do you drink alcohol at night? | <input type="radio"/> Y | <input type="radio"/> N |
| 25. Do you have sinus problems / allergies / asthma that is worse at night? | <input type="radio"/> Y | <input type="radio"/> N |
| 26. Does your sleep partner snore or keep you awake due to restlessness? | <input type="radio"/> Y | <input type="radio"/> N |
| 27. Have you ever had a concussive injury (black out due to head trauma)? | <input type="radio"/> Y | <input type="radio"/> N |
| 28. Is your insomnia related to your cycle? | <input type="radio"/> Y | <input type="radio"/> N |
| 29. Are you menopausal or have you had a hysterectomy? | <input type="radio"/> Y | <input type="radio"/> N |

Adrenal Health Questionnaire: Section C - Female Hormone

Pre & Peri Menopausal Women...

- | | | |
|---|-------------------------|-------------------------|
| 1. Do you experience frequent or irregular periods / menstruation? | <input type="radio"/> Y | <input type="radio"/> N |
| 2. Do you experience severe abdominal cramping with your period? | <input type="radio"/> Y | <input type="radio"/> N |
| 3. Do you get breast tenderness around the time of your periods? | <input type="radio"/> Y | <input type="radio"/> N |
| 4. Do you get moody or irritable during or just before your period? | <input type="radio"/> Y | <input type="radio"/> N |
| 5. Do you get heavy periods (heavy bleeding more than 2-3 days)? | <input type="radio"/> Y | <input type="radio"/> N |
| 6. Do you have uterine fibroids? | <input type="radio"/> Y | <input type="radio"/> N |
| 7. Do you have trouble getting to sleep because your mind is racing? | <input type="radio"/> Y | <input type="radio"/> N |
| 8. Have you had trouble getting pregnant or experienced a miscarriage? | <input type="radio"/> Y | <input type="radio"/> N |
| 9. Do you get anxiety or panic attacks? | <input type="radio"/> Y | <input type="radio"/> N |
| 10. Do you take or have you taken birth control pills in the past 2 years? | <input type="radio"/> Y | <input type="radio"/> N |
| 11. Have you gone with out a period for more than 3 months? | <input type="radio"/> Y | <input type="radio"/> N |
| 12. Have you experienced depression or post partum depression? | <input type="radio"/> Y | <input type="radio"/> N |
| 13. Do you get headaches / migraines around the time of your period? | <input type="radio"/> Y | <input type="radio"/> N |
| 14. Do you get cravings for sugar, fat, salt, or chocolate? | <input type="radio"/> Y | <input type="radio"/> N |
| 15. Do you experience pain during intercourse? | <input type="radio"/> Y | <input type="radio"/> N |
| 16. Do you get bloating and water retention during or around your period? | <input type="radio"/> Y | <input type="radio"/> N |
| 17. DO you take birth control pills, patches, injections, or hormone-types? | <input type="radio"/> Y | <input type="radio"/> N |
| 18. Do you have a family history or breast, uterine, or ovarian cancer? | <input type="radio"/> Y | <input type="radio"/> N |
| 19. Do you have endometriosis? | <input type="radio"/> Y | <input type="radio"/> N |

Post Menopausal Women...

- | | | |
|---|-------------------------|-------------------------|
| 1. Was your last menstrual period more than one year ago? | <input type="radio"/> Y | <input type="radio"/> N |
| 2. Do you get "hot flashes"? | <input type="radio"/> Y | <input type="radio"/> N |
| 3. Do you get severe sweating at night? | <input type="radio"/> Y | <input type="radio"/> N |
| 4. Do you have vaginal dryness? | <input type="radio"/> Y | <input type="radio"/> N |
| 5. Have you noticed vaginal thinning? | <input type="radio"/> Y | <input type="radio"/> N |
| 6. Do you notice a reduced libido? | <input type="radio"/> Y | <input type="radio"/> N |
| 7. Are you concerned for osteoporosis or hip / spinal fractures? | <input type="radio"/> Y | <input type="radio"/> N |
| 8. Do you have trouble getting to sleep because your mind is racing? | <input type="radio"/> Y | <input type="radio"/> N |
| 9. Do you get anxiety or panic attacks? | <input type="radio"/> Y | <input type="radio"/> N |
| 10. Do you experience pain during intercourse? | <input type="radio"/> Y | <input type="radio"/> N |
| 11. Do you take hormone replacement (pills, cream, patches, etc.)? | <input type="radio"/> Y | <input type="radio"/> N |
| 12. Do you have a family history of breast, uterine, or ovarian cancer? | <input type="radio"/> Y | <input type="radio"/> N |
| 13. Have you had a hysterectomy? | <input type="radio"/> Y | <input type="radio"/> N |