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 Medicade or Medicare patients at this time.** I herby 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?

O YES O NO

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

O YES O 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 is 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? *(Yes or No)*	If Yes, how often and how much?
Tobacco *(Chew, Smoke, Snuff)*	______	______
Alcohol	______	______
Caffeine *(Cola, Tea, Coffee)*	______	______
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.

Medication Name	Dose	Number of times per day	Doctor
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.

- ☐ Heart Disease
- ☐ Diabetes
- ☐ Cancer
- ☐ Epilepsy
- ☐ Hormone Related Issues
- ☐ Bladder Infections
- ☐ Blood Clots
- ☐ Diagnosed Obesity
- ☐ Lung Disease
- ☐ High Blood Pressure
- ☐ Depression
- ☐ Thyroid Disease
- ☐ Headaches
- ☐ Fatigue
- ☐ Abnormal PAP
- ☐ Prostate Cancer
- ☐ High Cholesterol
- ☐ Arthritis
- ☐ Ulcers
- ☐ Head Trauma
- ☐ Kidney Stones
- ☐ Insomnia
- ☐ Prader Willi Syndrome
- ☐ 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.

O Yes O No

b. Accomplished less than you would like.

O Yes O No

c. Were limited in the kind of work or other activities.

O Yes O No

d. Had difficulty performing at work or other activities *(for example, it took extra effort).*

O Yes O No

5. <u>During the past 4 weeks,</u> 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.

O Yes O No

b. Accomplished less than you would like.

O Yes O No

c. Were limited in the kind of work or other activities.

O Yes O No

d. Had difficulty performing at work or other activities *(for example, it took extra effort).*

O Yes O No

6. <u>During the past 4 weeks</u> 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 <u>during the past 4 weeks</u>?

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

8. <u>During the past 4 weeks</u>, 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 <u>during the past 4 weeks</u>. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time <u>during the past 4 weeks:</u> *(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, etc.)*?

- ☐ 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

b. I am as healthy as anybody I know
- ☐ 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

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.

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

QLS-H° Questions on Life Satisfaction - Hypopituitarism

Patient name ______________________________

Visit date __ __ / __ __ / __ __ __ __ (m m / d d / y y y y) Visit no. ____ Date of birth __ __ / __ __ / __ __ __ __ (m m / d d / y y y y)

The following areas of health apply mainly to people with hormone deficiencies. You should indicate how **important** the individual areas are to you personally, and then how **satisfied** you are with them.

Please answer **all** of the questions. Do not be influenced by whether you feel good or bad now. Think about **the last four weeks** when answering the questions.

First, please check how important each individual area is to your health. Before you begin, please read questions 1-9 below.

How important for you is your...	not important	slightly important	moderately important	very important	extremely important
1. ability to handle stress	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. body shape/appearance	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. self-confidence	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. ability to become sexually aroused	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. ability to concentrate	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. physical endurance	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. initiative/drive	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. your ability to deal with anger	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9. being able to stand the disturbances and noise of everyday life	☐ 1	☐ 2	☐ 3	☐ 5	☐ 5

Please mark how **satisfied** you are with these individual areas of your health. Think about the **last four weeks**, and answer **all** questions.

How satisfied are you with your...	dissatisfied	slightly dissatisfied	slightly satisfied	moderately satisfied	very satisfied
1. ability to handle stress	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. body shape/appearance	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. self-confidence	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. ability to become sexually aroused	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. ability to concentrate	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. physical endurance	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. initiative/drive	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. your ability to deal with anger	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9. being able to stand the disturbances and noise of everyday life	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Have any events you have experienced in the last four weeks influenced your satisfaction with life? If so, please specify.

____

Under what circumstances did you complete the questionnaire?

Place ____________ Date ____________ Time ____________

Quiet environment ☐ Noisy environment ☐ Alone ☐ Accompanied ☐

Please check all circumstances that apply.

Eli Lilly and Company
Indianapolis, Indiana 46285

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Lilly

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	☐	☐
I feel a strong need to sleep during the day	☐	☐
I often feel lonely even when I am with other people	☐	☐
I have to read things several times before they sink in	☐	☐
It is difficult for me to make friends	☐	☐
It takes a lot of effort for me to do simple tasks	☐	☐
I have difficulty controlling my emotions	☐	☐
I often lose track of what I want to say	☐	☐
I lack confidence	☐	☐
I have to push myself to do things	☐	☐
I often feel very tense	☐	☐
I feel as if I let people down	☐	☐
I find it hard to mix with people	☐	☐
I feel worn out even when I'm not doing anything	☐	☐
There are times I feel very low	☐	☐
I avoid responsibility if possible	☐	☐
I avoid mixing with people I don't know well	☐	☐
I feel as if I am a burden to people	☐	☐
I often forget what people said to me	☐	☐
I find it difficult to plan ahead	☐	☐
I am easily irritated by other people	☐	☐
I often feel too tired to do the things I ought to do	☐	☐
I have to force myself to do things that need doing	☐	☐
I often have to force myself to stay awake	☐	☐
My memory lets me down	☐	☐

Thyroid Function and Evaluation Tool

Name_________________________ Sex:________ Date:___/___/______ Problem:______________

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

Question	Score
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
Have you ever had trouble with fertility?	O Yes O No
Is your first morning under arm body temperature less than 97.8°F?	O Yes O No
Do you use any sort of thyroid supplementation?	O Yes O No

Androgen Deficiency in Aging Males Questionnaire

Instructions: Indicate your response by checking the appropriate box.

1. Do you have a decrease in libido (Sex Drive)? ☐Yes ☐No
2. Do you have lack of energy? ☐Yes ☐No
3. Do you have a decrease in strength and/or endurance? ☐Yes ☐No
4. Have you lost height? ☐Yes ☐No
5. Have you noticed a decreased "enjoyment of life"? ☐Yes ☐No
6. Are you sad and/or grumpy? ☐Yes ☐No
7. Are your erections less strong? ☐Yes ☐No
8. Have you noted a recent deterioration in your ability to play sports? ☐Yes ☐No
9. Are you falling asleep after dinner? ☐Yes ☐No
10. Has there been a recent deterioration in your work performance? ☐Yes ☐No

Self Assessment for Hypogonadism Questionnaire

What is your age? ☐60 or less ☐60 or Older

Have you ever been told by a health care professional that you have diabetes? ☐Yes ☐No

If yes, what type of treatment and how often? ☐Diet ☐Pills ☐Insulin injections

---

Have you ever been told by a health care professional that you have asthma? ☐Yes ☐No

If yes, are you receiving treatment? ☐Yes ☐No

If yes, what type of treatment and how often? ☐Pills ☐Everyday ☐Inhaler ☐Only when needed

How much do you usually sleep? ☐Less than 5 Hours ☐More than 5 Hours

Do you smoke cigarettes? ☐Yes ☐No

Have you recently been bothered by headaches? ☐Yes ☐No

Do you like directing other people's work? ☐Yes ☐No

Find the column for your height and weight. *(Find the column for your height and mark your weight. Fill in only one circle in this section.)*

5'0" or under
☐Under 135 pounds
☐135 - 150 pounds
☐Over 150 pounds

5'1" - 5'3"
☐Under 150 pounds
☐150-165 pounds
☐Over 165 pounds

5'4" - 5'6"
☐Under 160 pounds
☐160 - 180 pounds
☐Over 180 Pounds

5'7" - 5'9"
☐Under 180 pounds
☐180 - 195 pounds
☐Over 195 pounds

5'10" - 6'0"
☐Under 195 pounds
☐195-215 pounds
☐Over 215 pounds

6'1" - 6'3"
☐Under 210 pounds
☐210 - 235 pounds
☐Over 235 Pounds

6'4" - 6'6"
☐Under 230 pounds
☐230 - 255 pounds
☐Over 255 pounds

6'7" or over
☐Under 245 pounds
☐245-275 pounds
☐Over 275 pounds

AMS Questionnaire

Which of the following symptoms apply to you at this time? Please mark the appropriate box for each symptom. For symptoms that do not apply please mark "none".

Symptoms:

	None	Mild	Moderate	Severe	Extremely Severe
Score =	1	2	3	4	5
1. **Decline in your feeling of general well-being** (General state of health, subjective feeling)	☐	☐	☐	☐	☐
2. **Joint pain and muscular ache** (Lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
3. **Excessive sweating** (unexpected/sudden episodes of sweating, hot flushes independent of strain)	☐	☐	☐	☐	☐
4. **Sleep problems** (difficulty in falling asleep, difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	☐	☐	☐	☐	☐
5. **Increased need for sleep, often feeling tired**	☐	☐	☐	☐	☐
6. **Irritability** (feeling aggressive, easily upset about little things, moody)	☐	☐	☐	☐	☐
7. **Nervousness** (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
8. **Anxiety** (feeling panicky)	☐	☐	☐	☐	☐
9. **Physical exhaustion / lacking vitality** (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)	☐	☐	☐	☐	☐
10. **Decrease in muscular strength** (feeling of weakness)	☐	☐	☐	☐	☐
11. **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
12. **Feeling that you have passed your peak**	☐	☐	☐	☐	☐
13. **Feeling burnt out, having hit rock-bottom**	☐	☐	☐	☐	☐
14. **Decrease in beard growth**	☐	☐	☐	☐	☐
15. **Decrease in ability / frequency to perform sexually**	☐	☐	☐	☐	☐
16. **Decrease in the number of morning erections**	☐	☐	☐	☐	☐
17. **Decrease in sexual desire / libido** (lacking pleasure in sex, lacking desire for sexual intercourse)	☐	☐	☐	☐	☐

Have you got any other major symptoms? Yes ☐ No ☐

If Yes, please describe:

Adrenal Health Questionnaire: Section A

1 point for each yes

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

3 points for each yes

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

5 points for each yes

23. Do you suffer from chronic pain? ○Y ○N
24. Do you suffer from low blood sugar / hypoglycemia? ○Y ○N
    (i.e. headaches, sleepiness, mood swings if skipping meals)
25. Do you suffer from insomnia? ○Y* ○N

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**

Adrenal Health Questionnaire: Section B - Insomnia

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