



Adrenal Health Questionnaire: Section A

1 pt for each yes

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|--|---|---|
| 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. 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 (yes to any of these should trigger adrenal test)

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

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

If your score >20 it is highly probably you have adrenal dysfunction

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

*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

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



Adrenal Health Questionnaire: Section C - Female Hormone

Pre & Peri Menopausal Women...

Do you experience frequent or irregular periods/menstruation?	Y	N
Do you experience severe abdominal cramping with your period?	Y	N
Do you get breast tenderness around the time of your periods?	Y	N
Do you get moody or irritable during or just before your period?	Y	N
Do you get heavy periods (heavy bleeding more than 2-3 days)?	Y	N
Do you have uterine fibroids?	Y	N
Do you have trouble getting to sleep because your mind is racing?	Y	N
Have you had trouble getting pregnant or experienced a miscarriage?	Y	N
Do you get anxiety or panic attacks?	Y	N
Do you take or have you taken birth control pills in the past 2 years?	Y	N
Have you gone without a period for more than 3 months?	Y	N
Have you experienced depression or post partum depression?	Y	N
Do you get headaches/migraines around the time of your period?	Y	N
Do you get cravings for sugar, fat, salt, or chocolate?	Y	N
Do you experience pain during intercourse?	Y	N
Do you get bloating and water retention during around your period?	Y	N
Do you take birth control pills, patches, injections, or hormone-types?	Y	N
Do you have a family history of breast, uterine, or ovarian cancer?	Y	N
Do you have endometriosis?	Y	N

Post Menopausal Women...

Was your last menstrual period more than one year ago?	Y	N
Do you get "hot flashes"	Y	N
Do you get severe sweating at night?	Y	N
Do you have vaginal dryness?	Y	N
Have you noticed vaginal thinning?	Y	N
Do you notice a reduced libido?	Y	N
Are you concerned for osteoporosis or hip/spinal fractures?	Y	N
Do you have trouble getting to sleep because your mind is racing?	Y	N
Do you get anxiety or panic attacks?	Y	N
Do you experience pain during intercourse?	Y	N
Do you take hormone replacement (pills, creams, patches, ect)?	Y	N
Do you have a family history of breast, uterine, or ovarian cancer?	Y	N
Have you had a hysterectomy?	Y	N