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Adrenal Health Questionnaire: Section A

1 pt 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 (yes to any of these should trigger adrenal test)

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 exhaustion
If your score >20 it is highly probably 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

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Adrenal Health Questionnaire: Section B - Insomnia

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

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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