Reproductive Hormone – Female Assessment Scorecard

Name	

Based upon your health profile for the past 30 days, please select the appropriate number, from '0 - 3' on all questions (0 as least/never/no and 3 as most/always/yes). Circle the number you feel best applies, then add the numbers to create your score.

Point Scale:
(Please adjust your understanding as needed for health questions that are NOT symptom related.)
0 = NEVER (also: least, no, never tried/experienced)
1 = MILD (also: occasionally; symptom occurs rarely - i.e. a couple of times a month at most)
2 = MODERATE (also: some severity/intensity, and/or frequency, often; symptom occurs weekly)
3 = SEVERE/ABSOLUTE (also: frequent, intense, most, always, yes)

For all yes/no questions, **0 = No** and **3 = Yes**

Menstrual Cycle Years (Post-menopausal women answer based on function before menopause.)	**0**	**1**	**2**	**3**
Do you experience depression during periods?	0	1	2	3
Do you have mood swings associated with periods (PMS)?	0	1	2	3
Do you crave chocolate around periods?	0	1	2	3
Do you have breast tenderness associated with your cycle?	0	1	2	3
Do you have a history of menstrual disorders	0	1	2	3
Do you ever have excessive menstrual flow?	0	1	2	3
Do you ever have scanty blood flow during periods?	0	1	2	3
Do you have occasional skipped periods?	0	1	2	3
Are there variations in your menstrual cycles?	0	1	2	3
Do you have endometriosis?	0	1	2	3
Do you have uterine fibroids?	0	1	2	3
Do you have breast fibroids, benign masses?	0	1	2	3

Do you find intercourse painful (dysparenia)?	0	1	2	3
Do you ever notice vaginal discharge?	0	1	2	3
Do you ever notice vaginal dryness?	0	1	2	3
Do you ever notice vaginal itchiness?	0	1	2	3
Are you prone to gain weight around hips, thighs and buttocks?	0	1	2	3
Are you prone to excess facial or body hair?	0	1	2	3
Do you experience hot flashes?	0	1	2	3
Do you experience night sweats (in menopause females)?	0	1	2	3
Have you noticed thinning skin?	0	1	2	3
Have you noticed alternating menstrual cycle lengths?	0	1	2	3
Do you have an extended menstrual cycle, greater than 32 days? *0 = no* *3 = yes*	0	1	2	3
Do you have a shortened menses, less than every 24 days? *0 = no* *3 = yes*	0	1	2	3
Do you experience pain and cramping during periods?	0	1	2	3
Do you experience pelvic pain during menses?	0	1	2	3
Are you irritable and depressed during menses?	0	1	2	3
Do you experience acne break outs?	0	1	2	3
Do you have facial hair growth?	0	1	2	3
Have you noticed hair loss/thinning?	0	1	2	3
Do you feel disinterest in sex?	0	1	2	3
Are there nights when you cannot stay asleep?	0	1	2	3
Do you experience afternoon headache(s)?	0	1	2	3
Do you crave salt?	0	1	2	3
Are you a slow starter in the morning?	0	1	2	3
Do you experience afternoon fatigue?	0	1	2	3
Do you experience dizziness when standing up quickly?	0	1	2	3
Do you experience headache(s) with exertion or stress?	0	1	2	3
Do you tend to be a "night person"?	0	1	2	3

Do you have difficulty falling asleep?	0	1	2	3
Are you a slow starter in the morning?	0	1	2	3
Do you tend to be keyed up, and/or have trouble calming down?	0	1	2	3
Is your blood pressure above 120/80?	0	1	2	3
Do you experience headache(s) after exercising?	0	1	2	3
Do you feel wired or jittery after drinking coffee?	0	1	2	3
Do you clench or grind your teeth?	0	1	2	3
Are you calm on the outside, but troubled on the inside?	0	1	2	3
Do you have chronic low back pain that worsens with fatigue?	0	1	2	3
Do you become dizzy when standing up suddenly?	0	1	2	3
Do you have difficulty maintaining manipulative correction?	0	1	2	3
Do you experience pain after manipulative correction?	0	1	2	3
Do you have arthritic tendencies?	0	1	2	3
Do you crave salty foods?	0	1	2	3
Do you salt foods before tasting?	0	1	2	3
Do you perspire easily?	0	1	2	3
Do you have chronic fatigue and/or get drowsy often?	0	1	2	3
Do you have bouts of afternoon yawning?	0	1	2	3
Do you experience afternoon headache(s)?	0	1	2	3
Do you have asthma, wheezing, and/or difficulty breathing?	0	1	2	3
Do you experience pain on the medial or inner side of the knee?	0	1	2	3
Do you have a tendency to sprain ankles or experience "shin splints"?	0	1	2	3
Do you have a tendency to need sunglasses?	0	1	2	3
Do you have allergies and/or hives?	0	1	2	3
Do you ever suffer from weakness and/or dizziness?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Subtotal /192				
Menopausal Hormones (Menstruating women mark "0")	**0**	**1**	**2**	**3**

How many years have you been menopausal? *0 = none* *1 = 1 year* *2 = 2 years* *3 = 3 years or longer*	0	1	2	3
Do you ever have uterine bleeding since menopause?	0	1	2	3
Do you experience hot flashes?	0	1	2	3
Do you have issues with mental fogginess?	0	1	2	3
Are you disinterested in sex?	0	1	2	3
Do you experience mood swings?	0	1	2	3
Do you have issues with depression?	0	1	2	3
Do you notice that intercourse is painful?	0	1	2	3
Are your breasts shrinking?	0	1	2	3
Do you have facial hair growth?	0	1	2	3
Do you have acne?	0	1	2	3
Do you have increased vaginal pain, dryness or itching?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Subtotal /36				
Grand Total /228				

Calcucate Score

Grand Total: ____ x 100 = _____ %

What Your Score Means:

0 - 10% - Overall good balance. Sound nutrition and healthy habits will maintain good balance.

11 - 20% - In need of a tune up to restore balance before serious illness sets in. Diet and lifestyle improvements should shift to normal.

21 - 35% - Things are out of balance and need attention.

36 - 50% - Very compromised and likely to significantly affect your state of health, well-being and energy level.

51 - 100% - Severely compromised and requires immediate attention.