Hormonal Health Questionnaire: Perimenopausal Women

Personal Information

* Indicates required question

1. Full Name *

2. Client ID *

3. How would you describe your overall energy level? *

Check all that apply.

- [ ] Excellent
- [ ] Good
- [ ] Low
- [ ] Very low

4. Have you experienced unexplained weight gain or loss? *

5. Have you noticed any of the following in last 3 months: *

Check all that apply.

- [ ] Hair thinning or hair loss
- [ ] Dry skin or brittle nails
- [ ] Cold hands & feet
- [ ] Constipation or sluggish digestion
- [ ] Fatigue especially in the morning
- [ ] Difficulty losing weight even with diet & exercise
- [ ] Feeling thirsty all the time
- [ ] Passing urine more often
- [ ] Need to eat more often to feel full
- [ ] Irritable, shaky, or lightheaded when you skip meals
- [ ] Increased belly fat
- [ ] Energy crashes in the afternoon
- [ ] Feel fatigue throughout the day
- [ ] Feel anxious, overwhelmed, or unable to cope with stress
- [ ] Trouble falling asleep or staying asleep
- [ ] Craving for salt or salty foods

6. Menstruation History: *

Mark only one oval.

- ◯ Menstruating regularly
- ◯ Menstruating but irregular periods

7. Have you noticed changes in your menstrual cycle? (check all that apply)

Check all that apply.

- [ ] Shorter cycles
- [ ] Longer cycles
- [ ] Heavier Bleeding
- [ ] Lighter bleeding
- [ ] Missed periods
- [ ] Other: _____

8. Do you feel any of the following:experiences *

Check all that apply.

- [ ] Night sweats affecting
- [ ] Hot flushes
- [ ] Sleep disturbances
- [ ] Frequent UTIs
- [ ] Vaginal dryness
- [ ] Decreased sexual desire
- [ ] Mood swings or irritability
- [ ] Brain fog or poor concentration
- [ ] Difficulty to hold urine
- [ ] Leaking of urine while coughing/sneezing
- [ ] Musculoskeletal discomfort /stiffness/pain
- [ ] Severe headache/migraine
- [ ] Other: _____

9. How would you rate the impact of these symptoms on your quality of life?

Check all that apply.

- [ ] Severe
- [ ] Moderate
- [ ] Mild
- [ ] No impact
- [ ] Other: _____

10. Are you currently using any treatment for your symptoms? *

Mark only one oval.

- ◯ Yes – medical (HRT, pills, etc.)
- ◯ Yes – natural or alternative remedies
- ◯ No
- ◯ Estrogens cream

11. Do you actively track your menstrual cycle or symptoms?

Mark only one oval.

- ◯ Yes – with an app or journal
- ◯ Occasionally
- ◯ No
- ◯ Other: _____

12. Are you aware that perimenopause can last several years before menopause? *

Mark only one oval.

- ◯ Yes
- ◯ No

13. Would you like access to more resources or education on managing perimenopause? *

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Maybe