Adrenal Health Appraisal Questionnaire

Name: _____ Date: _____

Predisposing Factors		
1.	I have experienced long periods of stress that have affected my well being.	Yes
2.	I have had one or more severely stressful events that have affected my well being.	Yes
3.	I have driven myself to exhaustion.	Yes
4.	I overwork with little play or relaxation for extended periods.	Yes
5.	I have extended, severe or recurring respiratory infections.	Yes
6.	I have taken long term or intense steroid therapy (corticosteroids).	Yes
7.	I tend to gain weigh, especially around the middle (spare tire).	Yes
8.	I have a history of alcoholism and/or drug use.	Yes
9.	I have environmental sensitivities.	Yes
10.	I have diabetes (type II, adult onset)	Yes
11.	I suffer from post traumatic distress syndrome.	Yes
12.	I suffer from anorexia.	Yes
13.	I have one or more other chronic illnesses or diseases.	Yes

Frequently Observed Events		
1.	I get coughs and/or colds that stay around for several weeks.	Yes
2.	I have frequent or recurring bronchitis, pneumonia and/or other respiratory infections.	Yes
3.	I get asthma, colds and other respiratory involvements two or more times a year.	Yes
4.	I frequently get rashes, dermatitis, and/or other skin conditions.	Yes
5.	I have rheumatoid arthritis.	Yes
6.	I have allergies to several things in the environment.	Yes
7.	I have multiple chemical sensitivities.	Yes
8.	I have chronic fatigue syndrome.	Yes
9.	I get pain in the muscles of my upper back and lower neck for no apparent reason.	Yes
10.	I get pain in the muscles on the side of neck.	Yes
11.	I have insomnia and/or difficulty sleeping.	Yes
12.	I have fibromyalgia.	Yes
13.	I suffer from asthma.	Yes
14.	I suffer from hay fever.	Yes
15.	I suffer from nervous breakdowns.	Yes
16.	My allergies are becoming worse (more severe and/or frequent).	Yes
17.	The fat pads on palms of my hands and/or tips of fingers are often red.	Yes
18.	I bruise more easily than I used to.	Yes
19.	I have tenderness in my back near my spine at the bottom of my rib cage when pressed.	Yes
20.	I have swelling under my eyes upon rising that goes away after having been up for a couple of hours.	Yes
21.	I have increasing symptoms of premenstrual syndrome (PMS) such as cramps, bloating, moodiness, irritability, emotional instability, headaches, tiredness, and/or intolerance before my period (only some of these need be present).	Yes
22.	My periods are generally heavy but they often stop, or almost stop, on the fourth day, only to start up profusely on the 5^{th} or 6^{th} day.	Yes

Food Patterns		
1.	I need coffee or some other stimulant to get me going in the morning.	Yes
2.	I often crave food high in fat and feel better with high fat foods.	Yes
3.	I use high fat foods to drive myself.	Yes
4.	I often use high fat foods and caffeine containing drinks (coffee, colas, chocolate) to drive myself.	Yes
5.	I often crave salt and/or foods high in salt. I like salty foods.	Yes
6.	I feel worse if I eat high potassium foods (like bananas, figs, raw potatoes), especially if I eat them in the morning.	Yes
7.	I crave high protein foods (meats, cheeses).	Yes
8.	I crave sweet foods (pies, cakes, pastries, doughnuts, dried fruits, candies or desserts).	Yes
9.	I feel worse if I miss or skip a meal.	Yes

Energy Patterns		
1.	I often have to force myself to keep going. Everything seems like a chore.	Yes
2.	I am easily fatigued.	Yes
3.	I have difficulty getting up in the morning (I don't like to wake up till about 10:00 am)	Yes
4.	I suddenly run out of energy.	Yes
5.	I usually feel much better and fully awake after the noon meal.	Yes
6.	I often have an afternoon low between 3:00-5:00 PM.	Yes
7.	I get low energy, moody and/or foggy if I do not eat regularly.	Yes
8.	I usually feel my best after 6:00 PM.	Yes
9.	I am often tired at 9:00-10:00 PM, but resist going to bed.	Yes
10.	I like to sleep late in the morning.	Yes
11.	My best, most refreshing sleep often comes between 7:00-9:00 AM.	Yes
12.	I often do my best work late at night (early in the morning).	Yes
13.	If I don't go to bed by 11:00 PM, I get a second burst of energy around 11:00 PM, often lasting until 1:00-2:00 AM.	Yes

Key Signs and Symptoms		
1.	My ability to handle stress and pressure has became worse.	Yes
2.	I am less productive at work.	Yes
3.	I seem to have decreases in cognitive ability. I don't think as clearly as I used to.	Yes
4.	My thinking is confused when hurried and/or under pressure.	Yes
5.	I tend to avoid emotional situations.	Yes
6.	I tend to shake and/or I become nervous under pressure.	Yes
7.	I suffer from nervous stomach and/or indigestion when tense.	Yes
8.	I have many unexplained fears and/or anxieties.	Yes
9.	My sex drive is noticeably less than it used to be.	Yes
10.	I get lightheaded and/or dizzy when rising rapidly from a sitting or lying position.	Yes
11.	I have feelings of fainting and/or blacking out.	Yes
12.	I am chronically fatigued; a tiredness that is not usually relieved by sleep.	Yes
13.	I feel unwell much of the time.	Yes
14.	I notice that my ankles are sometimes swollen and/or the swelling is worse in the evening.	Yes
15.	I usually need to lie down or rest after sessions of psychological or emotional pressure and/or stress.	Yes
16.	My muscles sometimes feel weaker than they should.	Yes
17.	My hands and legs get restless – experience meaningless body movements.	Yes
18.	I have become allergic and/or have increased frequency and/or severity of allergic reactions.	Yes
19.	When I scratch my skin, a white line remains for a minute or more.	Yes
20.	Small irregular dark brown spots have appeared on my forehead, face, neck and/or shoulders.	Yes
21.	I sometimes feel weak all over.	Yes
22.	I have unexplained and frequent head aches.	Yes
23.	I am frequently cold.	Yes
24.	I have decreased tolerance for cold.	Yes

25.	I have low blood pressure.	Yes
26.	I often become hungry, confused, shaky and/or somewhat paralyzed with stress.	Yes
27.	I have lost weight without reason while feeling tired and listless.	Yes
28.	I have feelings of hopelessness and/or despair.	Yes
29.	I have decreased tolerance. People irritate me more.	Yes
30.	The lymph nodes in my neck are frequently swollen.	Yes
31.	I have times of nausea and vomiting for no apparent reason.	Yes
32.	Do you wear sunglasses outdoors due to light sensitivity	Yes

Aggravating Factors		
	I have constant stress in my life and/or work.	Yes
	My dietary habits tend to be sporadic and unplanned.	Yes
	My relationships at work and/or home are unhappy.	Yes
	I do not exercise regularly.	Yes
	I eat a lot of fruit.	Yes
	My life contains insufficient enjoyable activities.	Yes
	I have little control over how I spend my time.	Yes
	I restrict my salt intake.	Yes
	I have gum and/or tooth infections or abscesses.	Yes
	I have meals at irregular times.	Yes
	Please List Other Aggravating Factors:	Yes

Relieving Factors		
	I feel better almost right away once a stressful situation is resolved.	Yes
	Regular meals decrease the severity of my symptoms.	Yes
	I often feel better after spending a night out with friends.	Yes
	I often feel better if I lie down.	Yes
	Please List Other Relieving Factors:	Yes

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