



CHECKLIST FOR SYMPTOMS OF HORMONE IMBALANCE
FOR MEN

NAME _____ DATE _____

Basic Hormone Imbalance

Note which of the following symptoms are troublesome and/or persist over time.

<input type="checkbox"/> Burned out feeling	<input type="checkbox"/> Irritable	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Decreased urine flow
<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Erectile dysfunction	<input type="checkbox"/> Increased urinary urge	<input type="checkbox"/> Decreased stamina
<input type="checkbox"/> Weight gain waist	<input type="checkbox"/> Prostate problems	<input type="checkbox"/> Infertility problems	<input type="checkbox"/> Sleep disturbances
<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Decreased mental	<input type="checkbox"/> Oily skin	<input type="checkbox"/> Decreased muscle mass
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Sharpness	<input type="checkbox"/> Apathy	

Number selected _____

Adrenal Hormone Imbalance

Note which of the following symptoms are troublesome and/or persist over time.

<input type="checkbox"/> Aches and pains	<input type="checkbox"/> Elevated triglycerides	<input type="checkbox"/> Morning fatigue	<input type="checkbox"/> Bone loss
<input type="checkbox"/> Sleep disturbances	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Blood sugar imbalance
<input type="checkbox"/> Infertility	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Allergic conditions	<input type="checkbox"/> Autoimmune illness
<input type="checkbox"/> Chronic illness	<input type="checkbox"/> Evening fatigue	<input type="checkbox"/> Susceptibility to infections	

Number selected _____

Thyroid Hormone Imbalance

Note which of the following symptoms are troublesome and/or persist over time.

<input type="checkbox"/> Constipation	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Brittle nails	<input type="checkbox"/> Depression
<input type="checkbox"/> Dry skin	<input type="checkbox"/> Cold hands and feet	<input type="checkbox"/> Headaches	<input type="checkbox"/> Infertility
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Foggy thinking	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Feeling cold all the time
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Low libido	<input type="checkbox"/> Inability to lose weight	<input type="checkbox"/> Sleep disturbances
<input type="checkbox"/> Thinning hair	<input type="checkbox"/> Menstrual irregularities	<input type="checkbox"/> Elevated cholesterol	<input type="checkbox"/> Thinning eyebrows

Number selected _____