TOOLS for WELLNESS®
Live Smarter®

RESTORE *Menopause Relief Formula* Self Assessment

Self Assessment of Symptoms Form. Please note this assessment form is for personal use to aid in tracking progress monitoring. Any concerns should be addressed with your health practitioner.

This form is designed to establish a baseline of current health conditions and then monitor changes and improvements. Changes can be subtle so recording changes can help greatly to see improvements.

Prior to starting this formula, please first complete this form so that there is baseline information
Then, after the: 1st month 2nd month 3rd month

Date each form when completed. It is very important for all items to be checked.

Name: _____ Date: _____

Age ____ Weight _____ Do you consume alcohol? No _____ Yes _____

If yes, how many drinks do you have on average the days you drink _____

If yes, how many days do you drink each week _____ Add explanation or details if helpful _____

_____

Do you consider yourself (please circle) thin ___ normal ___ a little overweight ___ a lot overweight ___

Current weight loss or weight management therapy, if any: Please describe: _____

_____ _____

Are you currently taking any blood thinning, blood sugar, high blood pressure/hypertension medications?

No ___ Yes ___. If yes, please give the names: _____

Are you taking any prescription drugs such as anti-depressants or anti-anxiety drugs which have adverse side effects that may compromise physical intimacy desire and function?

No ___ Not sure ___ Yes ___ If yes, please list _____

Quality of Life, including energy, sleep, desire for emotional or physical intimacy, covers a wide spectrum of symptoms - some apply to certain women and not to others. Some entries may seem unrelated to physical conditions, but are included due to the vascular or neural influences of certain cell-signaling factors.

Check √ or write"0" under No if you do not currently observe or experience the symptom listed.

Check "1 to 10" if you currently observe the symptom listed.

If "**yes**", please assign a number from 1 to 10 to indicate the degree of the symptom:

1 = very mild, or very decreased or reduced 10 = very severe, or very increased

On a scale of 1 to 10,

___ Rate your overall stress level? 1 none, 10 extremely stressed

___ Rate your overall quality of life. 1 wonderful, 10 very bad

___ Rate the impact age changes have had on the physical challenges on your sex life.
1 minimal, 10 severely impacted

Please remember to complete each entry.

Physical Constitution

No Yes If Yes, score 1 = very mild or hardly noticeable 10 = very severe

___ ___ General Daytime Fatigue

___ ___ Amount of excess / unwanted visceral (abdominal) fat: # of ___ lbs wanting to lose

___ ___ Unwillingness to be Physically Active

This past week did you have a desire to be physical intimate yes ___ no ___

If yes, how many times each week does it happen ___
If yes, did you consummate those feelings yes ___ no ___ sometimes ___

Gastrointestinal/Abdominal

No Yes If yes, score 1=very mild 10=very severe

___ ___ Bloated feeling after eating
___ ___ IBS (irritable bowel syndrome) UC or Crohn's
___ ___ Diarrhea that is undiagnosed
___ ___ Chronic issues with constipation

Urinary

No Yes If yes, score 1=very mild 10=very severe

___ ___ Difficulty starting to urinate when ready
___ ___ Difficulty to stop urinating – dripping, once done
___ ___ Once done urinating, still feeling the need to go – bladder never seems emptied
___ ___ Wake up at night with the 'need to go'. If regularly - how many times a night? ___

Respiratory

No Yes If yes, score 1=very mild 10=very severe

___ ___ Shortness of breath or easily tired when doing physical activities.
___ ___ Need to use asthma meds

Neurological

No Yes If yes, score 1=very mild 10=very severe

___ ___ Frequent headaches
___ ___ Mental confusion, problems with short-term memory
___ ___ Dizziness

Sexual Performance

No Yes If yes, score 1 = very mild 10 = very severe / difficult

___ ___ Difficulty becoming physically stimulated to have sex
___ ___ Difficulty in achieving climax
___ ___ Difficulty achieving vaginal moistness to make sex pleasurable and not painful

___ ___ Difficulty maintaining interest once intimacy has begun
___ ___ Problem with vaginal dryness

Sleep

No Yes If yes, score 1 = very mild 10 = very severe
___ ___ Fitful sleeping / irregular sleep patterns
___ ___ Unable to go to sleep / insomnia

Psychological

No Yes If yes, score 1 = very mild, rarely 10 = very severe, debilitating
___ ___ Problems with recall or short-term memory
___ ___ Anxiety about lack of desire to become intimate sexually
___ ___ Not feeling sexually attractive to a partner
___ ___ Unable to feel calm or relaxed
___ ___ Feeling depressed or unhappy
___ ___ Feeling anxious or stressed

Appetite / Oral

No Yes If yes, score 1=very mild, 10=very severe
___ ___ Excessive sugar cravings or desire for sweets
___ ___ Excessive salt cravings or desire for salty foods

Musculoskeletal

No Yes If yes, score 1=very mild 10=very severe
___ ___ Muscle tension, soreness or tightness in movements, especially upon wakening.
___ ___ Joint pain or rheumatoid arthritis
___ ___ Other, if so, please describe _____

Other Symptoms – please add additional observances, thoughts, or feelings.

No Yes Score (1-10)
___ ___ _____ _____

___ ___ _____

___ ___ _____

Prescription Drug use? If so, what?

_____

_____

Please hold onto your assessment each time completed for reference or to provide to your health care provider.