TOOLS for WELLNESS
Live Smarter®

# RESTORE -Yinergy - Womens Aging & Balance 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.*

Prior to using this formula, complete this form so you can create a baseline for success
Then, after the: 1st month 2nd month 3rd month

Date each form when completed. Make sure to complete assessment in full.

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 7 = very severe, or very increased

## On a scale of 1 to 10,

___ Rate your overall stress level? 1 none, 7 extremely stressed

___ Rate your overall quality of life. 1 wonderful, 7 very bad

___ Rate the impact age changes have had on the physical challenges on your sex life.
1 minimal, 7 severely impacted

**Please remember to complete each entry.**

## Physical Constitution

No Yes If Yes, score 1 = very mild or hardly noticeable 7 = 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 7 = 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 7 = 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 7 = 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 7 = very severe

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

## Sexual Performance

No Yes If yes, score 1 = very mild 7 = 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 7 = very severe

___ ___ Fitful sleeping / irregular sleep patterns
___ ___ Unable to go to sleep / insomnia

**Psychological**

No Yes If yes, score 1 = very mild, rarely 7 = 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, 7 = 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 7 = 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 (1-7)
___ ___ _____ _____

___ ___ _____

___ ___ _____

Prescription Drug use? If so, what?

_____

_____

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