Metabolic Hormones Assessment

(Insulin, Cortisol, Digestion, Adrenals, Thyroxin, Fatty Liver, Melatonin, & Leptin)

Identify the metabolic hormones or conditions that contributes to your sluggish metabolism.

Learn how to rebuild, reboot, and restore a sluggish metabolism and stop weight gain.

Instruction: **Answer with a YES or NO for each question, add up the Yes's only.**

1. Major Metabolic Hormone:	**YES**	**~~NO~~**
1) Do you crave sweets, and give in to eating them for an energy boost and then feel tired, weak and or need a nap?		
2) Do you have a family history of diabetes, hypoglycemia or alcoholism?		
3) Do you feel irritable, anxious, tired, and jittery and or develop a mild headache until you eat or have a snack?		
4) Do you feel weak, low energy and jittery 2 to 3 hours after a meal?		
5) Do you eat a low-fat diet but can't seem to lose weight?		
6) Do you feel irritable, tired and weak when you skip meals?		
7) When you eat a carbohydrate breakfast (toast, bagel, cereal, pancakes), can you control your carbohydrate for the rests of the day?		
8) Once you start eating sweets & starches, do you continue to eat these foods?		
9) Do you feel sleepy after eating a full meal of pasta, bread, rice, or potatoes?		
10) Do you go for the bread basket at a restaurant?		
11) Do you get heart palpitations after eating sweets?		
12) Do you suffer from panic attacks in the afternoon if you miss breakfast?		
13) Do you skip breakfast often?		
14) Do you get moody, impatient or anxious easily?		
15) Is your memory and concentration failing or poor?		
16) Do you experience night sweats?		
17) Do you feel thirsty most of the time?		
18) When you eat, do you have a calming, enjoyable feeling?		
19) Do you retain fluids when you use salt?		
20) Do you get tired easily especially after eating?		
21) Do you wake up feeling tired, or feel tired most of the day?		
22) Have you been diagnosed with Type 1 or 2 Diabetes?		
23) Did you experience gestational diabetes during pregnancy?		
24) Do you eat salty, fatty or sweet foods before going to bed?		
Total the Yes's ONLY		

2. Major Metabolic Hormone:	**YES**	**~~NO~~**
1) Do you have low blood pressure?		
2) Do you get dizzy when you stand up?		
3) Do you experience low blood sugar (hypoglycemic)?		
4) Do you crave salt?		
5) Do you have dark circles under your eyes?		

6) Do you have difficulties falling asleep and or staying asleep?		
7) Do you feel foggy and sluggish when you wake up in the morning?		
8) Do you get headaches easily and or often?		
9) Do you experience mental fogginess or trouble concentration?		
10) Do you get tired during exercise, and tired after exercise?		
11) Do you get a cold each year, or often?		
12) Do you feel depressed and overwhelmed with life?		
13) Do you feel up tight or stressed out often?		
14) Do you feel irritable, fatigued, low-energy most of the day?		
15) Do you retain fluids around your ankles in the evening?		
16) Do you startle or scare easily?		
17) Do you experience heart palpitations when you're in a stressful experience?		
18) Do you need to start the day with more than one coffee or tea?		
19) Do you have an alcoholic drink at the end of your day often?		
20) Do you get sweaty palms and feet when under stress?		
21) Do you have a daily nap?		
22) Do you feel like your muscles are weak with poor posture?		
23) Do you lack "libido" sexual interest?		
Total the Yes's ONLY		

3. Metabolic System:	**YES**	**~~NO~~**
1) Do you feel bloated after you eat a meal?		
2) Do you belch or pass gas after you have eaten a meal?		
3) Do you have intestinal cramps with a loose bowel movement after a meal?		
4) Do you have a soft, free flowing bowel movement daily?		
5) Do you experience frequent constipation and laxatives?		
Total the Yes's ONLY		

4. Major Glands:	**YES**	**~~NO~~**
1) Do you have food allergies or environmental allergies?		
2) Do you have food allergies?		
3) Are you exposed to pesticides, toxic chemicals, and or heavy metals?		
4) Do you have a history of chronic infections; hepatitis, bronchitis & or cold sores?		
5) Do you suffer from chronic sinusitis?		
6) Do you have chronic asthma?		
7) Do you have skin problems; dermatitis – eczema, acne, rashes, bruising?		
8) Do you suffer from arthritis?		
9) Do you have an autoimmune disorders; fibromyalgia, lupus, rheumatoid arthritis?		
10) Do you have a spastic bowel (irritated bowel syndrome)?		
11) Do you suffer from a mental illness; ADHD, autism, mood swings, bipolar?		
12) Do you have cardiovascular disease; high blood pressure, elevated cholesterol?		
13) Is there a family history of Parkinson's, Alzheimer's or dementia?		
14) I your daily regiment at home and at work stressful to you?		
15) Did you have a stressful childhood and or upbringing?		
16) Do you drink alcohol more than 3 times a week?		
17) Do you smoke cigarettes or cannabis?		
18) Do you take medication for mental wellness?		

19) Do you engage and enjoy exercising?		
20) Do you enjoy walking and swimming?		
21) Do you exercise 3 times a week?		
22) Do you have exercise limitations that hold you back?		
23) Are you happy with your stress level now?		
Total the Yes's ONLY		

5. Major Hormone:	**YES**	~~**NO**~~
1) Do you have thick finger nails?		
2) Do you have dry itchy skin?		
3) Do you have a hoarse voice?		
4) Do you have thinning hair?		
5) Are you cold when everyone is warm?		
6) Is your Basal Body Temperature 97.8 upon waking in the morning? (Use basal thermometer under the arm for 3 minutes to find out.)		
7) Do you have cold hands and feet all the time?		
8) Do you have muscle fatigue, pain and weakness?		
9) Do you have heavy menstrual bleeding monthly?		
10) Do you have a low sex drive?		
11) Do you have menopause symptoms; hot flashes, night sweats, sugar cravings?		
12) Do you experience swelling in the hands and feet?		
13) Do you experience extreme fatigue?		
14) Do you have elevated cholesterol levels?		
15) Do you have problem with memory, brain fog, and concentration?		
16) Do you feel rested when you wake up in the mornings?		
17) Do you have a loss or thinning of both eye brows?		
18) Do you struggle with weight loss?		
19) Do you experience constipation often?		
20) Do you have a puffy face?		
21) Are you diagnosed with an autoimmune disease?		
22) Do you drink chlorinated or fluorinated water?		
23) Have you been exposed to radiation treatments?		
24) Do you take the antipsychotic medication Lithium?		
25) Do you have a puffy distinctive puffiness around the neck?		
26) Have you recently experience a fast, unexplainable weight gain lately?		
Total the Yes's ONLY		

6. Metabolic Condition:	**YES**	~~**NO**~~
1) Are your bowel movements irregular such as every other day?		
2) Do you urinate small amounts of dark, strong smelling urine?		
3) Do you rarely break out into a strong sweat?		
4) Do you have one or more of the following: fatigue, muscle aches, headaches?		
5) Do you drink tap water?		
6) Do you have cloths dry cleaned?		
7) Do you live or work in a poorly ventilated building?		
8) Do you live in an industrial area?		
9) Do you use, lawn, bug and or garden chemicals?		
10) Do you have one or more mercury silver fillings?		

11) Do you eat swordfish, tuna, shark, and shell fish more than once a week?		
12) Do you consume caffeine daily?		
13) Do you consume medication for any of the following; diarrhea, indigestion, heart burn, birth control, prostate, and Crohn's and or colitis?		
14) Do you have a negative reaction to MSG, sulfites, sodium benzoate, and red wines?		
15) Have you ever had jaundice or shingles?		
16) Do you have a history of breast cancer, prostate problems, or cancer?		
17) Do you have a family history of Parkinson's, Alzheimer's or multiple sclerosis?		
18) Do you use over the counter main medicine such as Tylenol?		
19) Do you have a family history of liver disease?		
Total the Yes's ONLY		

7. Metabolic Disorder:	**YES**	~~**NO**~~
1) Are you fatigued on a daily basis?		
2) Do you have muscle-aches and pains often?		
3) Are you sensitive to perfume, smoke, and dust?		
4) Are you exposed to any level of environmental pollutants?		
5) Do you use tobacco or cannabis products?		
6) Are you exposed to sunning or ultra violet light more than one hour a week?		
7) Do you take prescription drugs?		
8) Would you say your daily stress level is high?		
9) Do you eat fried, or fats foods 3 times a week?		
10) Do you eat less than a ½ cup of deeply colored vegetables a day?		
11) Do you eat your food fast?		
12) Do you usually take seconds a most meals?		
13) Do you tend to overeat at most meals?		
14) Do you clean up your plate at most meals?		
15) Do you think you have a problem with food?		
16) Do you order take out twice a week?		
17) Do you secretly hide food from others?		
18) Do you crave foods you know are bad for you?		
19) Do you plan and prepare all your meals?		
20) Do you ask others to get you food?		
21) Do other people generally prepare your meals?		
22) Are you under prolong stress?		
23) Do you feel sick or fluish often for no reason?		
24) Do you have chronic fatigue or fibromyalgia?		
Total the Yes's ONLY		

8. Metabolic Hormone:	**YES**	~~**NO**~~
1) Have you gained most of your weight around your belly?		
2) Do you mostly crave carbohydrates?		
3) Do you skip breakfast often?		
4) Do you eat within 2 hours of going to bed?		
5) Do you snore, is it a problem?		
6) Do you eat less than three times a day?		
7) Do you feel stressed on a regular basis?		

8) Do you eat even though you're not hungry?		
9) Do you drink soda pop drinks more than twice a day?		
10) Do you take sugar in your coffee or tea?		
11) Do you crave a cookie, donut or sweets for a snack?		
12) Do you eat when watching TV?		
13) Do you get a second wind of energy in the evening?		
14) Do you have a sedentary lifestyle?		
15) Do you believe your lifestyle is to blame for you weight gain?		
16) Do you believe your lifestyle is to blame for your eating habits?		
17) Do you like your present lifestyle?		
18) Do you believe you have and active lifestyle?		
19) Have you been a night snacker for more than five years?		
20) Do you have more than three alcohol beverages a week?		
21) Are you considered a night owl – like to stay up late in the evening?		
22) Do you get 8 hrs of sleep each evening?		
23) Do you feel rested when you wake in the morning?		
24) Do you have dreams, and or nightmares?		
25) Do you have a sleep disorder?		
26) Do you need oxygen on a regular basis?		
27) Do you need any sleep aids or breathing devices?		
28) Do you drink sports or energy drinks daily?		
29) Do you feel hungry upon waking in the morning?		
Total the Yes's ONLY		

Results: HIGHER the number of YES'S will represent a metabolic imbalance or hormonal disturbance.

Total # of Yes's

1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	

List your metabolic weakness (s)

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