



Hormonal Imbalance

Self-Assessment Quiz

Please fill out these details to the best of your ability and with unbiased honesty.

Name _____ Gender _____ Age _____

Instructions:

For each category below, check the symptoms that apply to you.

- *Scoring >4 points in any category suggests you may have a hormonal imbalance in that area.*
- *Scoring >8 points indicates a more significant imbalance.*
- *It's common to have more than one imbalance. The goal is not perfection, but awareness – so you can start addressing the underlying root causes and move toward balance.*



HORMONAL IMBALANCE SELF-ASSESSMENT QUIZ

High Estrogen

	0 = Never/Rarely	1 = Sometimes	2 = Frequently
Heavy periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short menstrual cycles (<21 days)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating, fluid retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness, cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of using estrogen-containing birth control in the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score for This Section: _____



HORMONAL IMBALANCE SELF-ASSESSMENT QUIZ

Low Estrogen

	0 = Never/Rarely	1 = Sometimes	2 = Frequently
Irregular or absent periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling asleep, Waking up in the middle of the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety, depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes, night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent UTI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain fog, poor memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint aches or pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of bone density (osteopenia, osteoporosis, loss of height)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long menstrual cycles or scant period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score for This Section: _____



HORMONAL IMBALANCE SELF-ASSESSMENT QUIZ

Low Progesterone

	0 = Never/Rarely	1 = Sometimes	2 = Frequently
Irregular or absent periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia, sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety, depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short luteal phase (ovulation to menstruation less than 12 days)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spotting in the second half of your cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low or no signs of ovulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low basal body temperature in luteal phase	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fertility problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent miscarriage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms of excess estrogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines, Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms of excess estrogen (weight gain, low libido, breast tenderness, fibrocystic breasts, fibroids, gallbladder problems)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score for This Section: _____



HORMONAL IMBALANCE SELF-ASSESSMENT QUIZ

High Testosterone

	0 = Never/Rarely	1 = Sometimes	2 = Frequently
Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skipped periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fertility challenges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair in unwanted places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss (head)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggression, irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCOS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High LDL cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score for This Section: _____



HORMONAL IMBALANCE SELF-ASSESSMENT QUIZ

Low Testosterone

	0 = Never/Rarely	1 = Sometimes	2 = Frequently
Fatigue, sluggishness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness or loss of muscle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss (head)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sexual satisfaction, difficulty achieving orgasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular menstrual cycles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score for This Section: _____



HORMONAL IMBALANCE SELF-ASSESSMENT QUIZ

High Insulin/Insulin Resistance

	0 = Never/Rarely	1 = Sometimes	2 = Frequently
Irregular or absent periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling asleep, Waking up in the middle of the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety, depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes, night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent UTI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain fog, poor memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint aches or pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of bone density (osteopenia, osteoporosis, loss of height)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long menstrual cycles or scant period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score for This Section: _____