

FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____ EMAIL: _____

TODAY'S DATE: _____ PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)					
Sleep Problems (difficulty falling asleep or sleeping through the night)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)					
Decline in drive or interest (loss of "zest for life," feeling down or sad)					
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)					
Difficulties with memory (concentration, finding the right word, or retaining information)					
Vaginal dryness or difficulty with sexual intercourse					
Sexual Problems (change in desire, activity, orgasm and/or satisfaction)					
Sweating (night sweats or increased episodes of sweating)					
Hot Flashes (burst that starts in chest and lasts for short duration)					
Hair loss, thinning or change in texture of hair					
Feeling cold all the time, having cold hands or feet					
Headaches or migraines (increase in frequency or intensity)					
Weight (difficulty losing weight despite diet/exercise)					
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)					

Other symptoms or unique health circumstances to take into consideration:
