Pre-Treatment Questionnaire

Name: _____ Date: _____

Please evaluate your feelings about your health on each of the following categories. Check (use a check mark) the number that corresponds to your self-assessment, where the range is from 10=excellent to 1=very poor.

	<=EXCELLENT									VERY POOR=>
	10	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
Muscle Strength										
Muscle Size										
Recovery time following exercise										
Joint Flexibility										
Ability to tolerate exercise										
Endurance										
Overall Energy										
Percent Body Fat										
Absence of fat deposits										
Lean Body Mass										
Metabolism										
Skin thickness										
Skin texture										
Skin oiliness										
Skin elasticity										
Lack of wrinkles										
Hair growth rate										
Hair retention										
Hair color retention										
Hearing										
Vision										
Healing of injuries										
Resistance to diseases										
Freedom from allergies										

Pre-Treatment Questionnaire

Name: _____ Date: _____

	<=EXCELLENT									VERY POOR=>
	10	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
Sexual desire										
Genital function										

Frequency of urination										
Frequency of nighttime urination										
Regular bowel movements										
Lack of inappropriate sweating or chills										

Healthy appetite										
Control of eating										
Ability to sleep										
Feeling rested in the morning										

Mental Energy										
Emotional stability										
Social interactions										
Memory										
Concentration										
Feeling of well-being										
Attitude toward life										

DO not fill out this portion.

Condition	**Suggested**	**ICD-10**	**Supported**
Hypogonadism			
Primary Ovarian Failure			
Central Hormonal Deficiency			
Depression – Hormonal			
Adult GH Insufficiency			
Traumatic Brain Injury			