

TEST REPORT

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D2026 05 06 030 S

Ordering Provider:
Getuwell

Samples Received
05/06/2026

Report Date
05/15/2026

Samples Collected
Saliva - 05/01/26 06:30
Saliva - 05/01/26 12:00
Saliva - 05/01/26 18:00
Saliva - 05/01/26 22:00

Patient Name: Saliva LCMS Hormones 7 with 4-Point Cortisol
Patient Phone Number:

Gender	Last Menses	Height	Waist
Female	04/10/2026	5 ft 5 in	Unspecified
DOB	Menses Status	Weight	BMI
1/1/1997 (29 yrs)	Pre-Menopausal - Irregular	130 lb	21.6

TEST NAME	RESULTS 05/01/26	RANGE
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Salivary Steroids & Other Analytes (LC-MS/ECLIA)

Estradiol	1.8	1.0-2.9 pg/mL Premeno-luteal
Estriol	1.0	<3.0 pg/mL Premenopausal Luteal
Estrone	2.9 L	3.2-7.9 pg/mL Premeno-luteal
Progesterone	100	66-196 pg/mL Premeno-luteal
Ratio: Pg/E2 (Saliva LCMS)	56	23-196
Testosterone	8	7-22 pg/mL
DHEAS	0.9	0.8-8.0 ng/mL
Cortisol	6.1	2.5-6.2 ng/mL (morning)
Cortisol	1.5	1.11-2.74 ng/mL (noon)
Cortisol	0.7	0.61-1.33 ng/mL (evening)
Cortisol	0.2 L	0.25-0.64 ng/mL (night)

<dl = Less than the detectable limit of the lab. N/A = Not applicable; 1 or more values used in this calculation is less than the detectable limit. H = High. L = Low.

Therapies

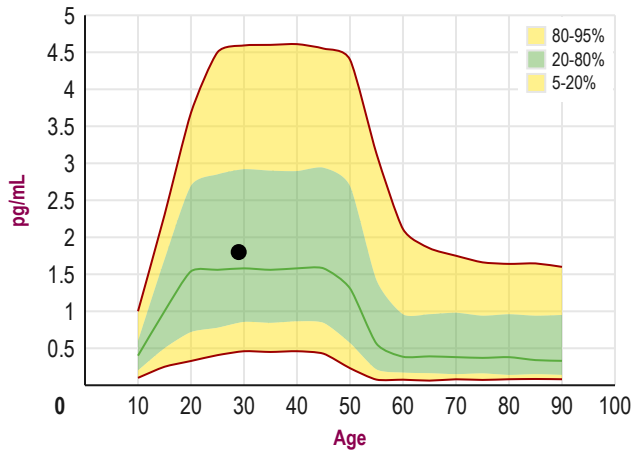
None Indicated

Graphs

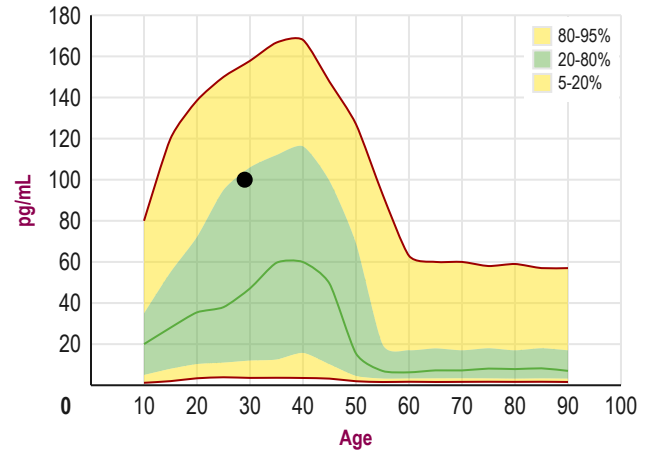
Disclaimer: Graphs below represent averages for healthy individuals not using hormones. Supplementation ranges may be higher. Please see supplementation ranges and lab comments if results are higher or lower than expected.

— Average ▼▲ Off Graph

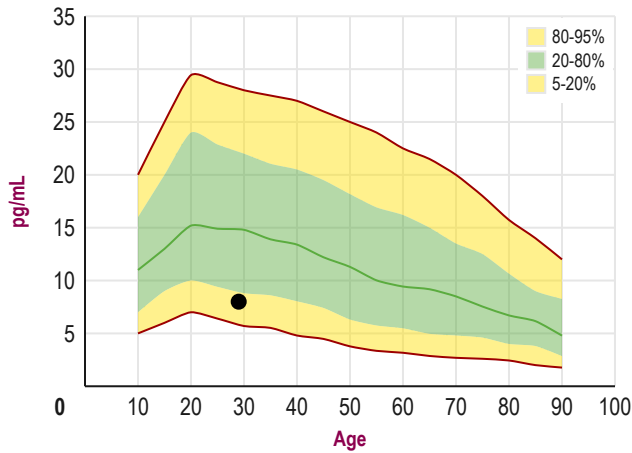
Saliva Estradiol



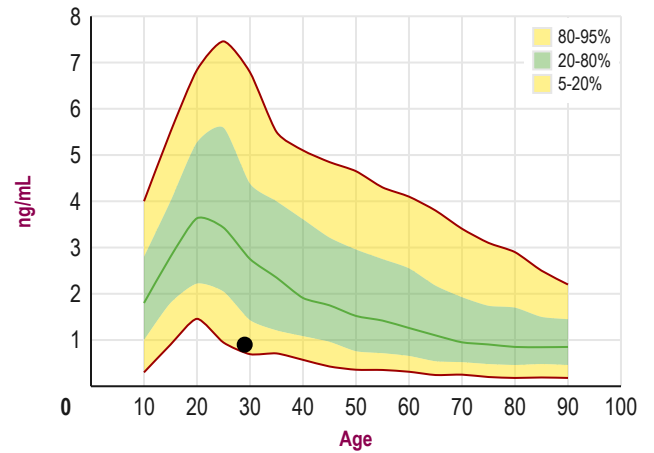
Saliva Progesterone



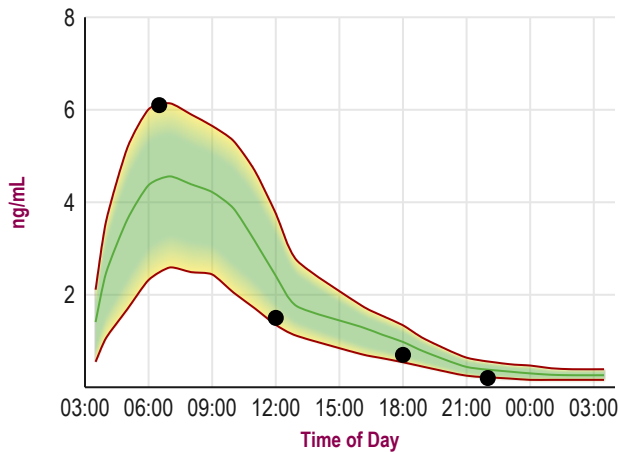
Saliva Testosterone



Saliva DHEAS



Saliva Cortisol



TEST REPORT | Patient Reported Symptoms

Saliva LCMS Hormones 7 with 4-Point Cortisol
D2026 05 06 030 S

Disclaimer: Symptom Categories below show percent of symptoms self-reported by the patient compared to total available symptoms for each category. For detailed information on category breakdowns, go to www.zrtlab.com/patient-symptoms.

SYMPTOM CATEGORIES		RESULTS 05/01/26
Estrogen / Progesterone Deficiency	10%	<div style="width: 10%;"></div>
Estrogen Dominance / Progesterone Deficiency	9%	<div style="width: 9%;"></div>
Low Androgens (DHEA/Testosterone)	3%	<div style="width: 3%;"></div>
High Androgens (DHEA/Testosterone)	5%	<div style="width: 5%;"></div>
Low Cortisol	2%	<div style="width: 2%;"></div>
High Cortisol	13%	<div style="width: 13%;"></div>
Hypometabolism	10%	<div style="width: 10%;"></div>
Metabolic Syndrome	18%	<div style="width: 18%;"></div>

SYMPTOM CHECKLIST	MILD	MODERATE	SEVERE
Aches and Pains			
Acne			
ADD/ADHD			
Addictive Behaviors			
Allergies			
Anxious			
Autism Spectrum Disorder			
Bleeding Changes			
Blood Pressure High			
Blood Pressure Low			
Blood Sugar Low			
Body Temperature Cold			
Bone Loss			
Breast Cancer			
Breasts - Fibrocystic			
Breasts - Tender			
Chemical Sensitivity			
Cholesterol High			
Constipation			
Depressed			
Developmental Delays			
Eating Disorders			
Fatigue - Evening			
Fatigue - Morning			
Fibromyalgia			
Foggy Thinking			
Goiter			
Hair - Dry or Brittle			
Hair - Increased Facial or Body			
Hair - Scalp Loss			
Headaches			
Hearing Loss			
Heart Palpitations			
Hoarseness			
Hot Flashes			
Incontinence			
Infertility			
Irritable			
Libido Decreased			
Mania			

CLIA Lic # 38D0960950
5/15/2026 11:19:29 AM

The above results and comments are for informational purposes only and are not to be construed as medical advice. Please consult your healthcare practitioner for diagnosis and treatment.

David T. Zava

David T. Zava, Ph.D.
Laboratory Director

Alison McAllister

Alison McAllister, ND.
(Ordering Provider unless otherwise specified on page 1)

SYMPTOM CHECKLIST	MILD	MODERATE	SEVERE
Memory Lapse			
Mood Swings			
Muscle Size Decreased			
Nails Breaking or Brittle			
Nervous			
Night Sweats			
Numbness - Feet or Hands			
OCD			
Panic Attacks			
PreMenstrual Dysphoric Disorder			
Pulse Rate Slow			
Rapid Aging			
Rapid Heartbeat			
Skin Thinning			
Sleep Disturbed			
Stamina Decreased			
Stress			
Sugar Cravings			
Sweating Decreased			
Swelling or Puffy Eyes/Face			
Tearful			
Triglycerides Elevated			
Urinary Urge Increased			
Uterine Fibroids			
Vaginal Dryness			
Water Retention			
Weight Gain - Hips			
Weight Gain - Waist			

Lab Comments

ESTROGENS: ESTRADIOL, ESTRONE, ESTRIOL

Estradiol and estriol are within normal reference ranges for a premenopausal woman during luteal phase of the menstrual cycle. Estrone, the inactive metabolite of estradiol, is slightly lower than reference range. During luteal phase of the menstrual cycle estradiol, the most potent of the three estrogens, should be well balance with natural progesterone at an ideal progesterone/estradiol ratio of about 100-300. If symptoms of estrogen imbalance are problematic consider progesterone therapy, which can help with symptom of both estrogen excess (helps clear excessive estrogens) and estrogen deficiency (helps bolster beneficial actions of estrogen when within lower normal luteal levels).

PROGESTERONE is within the reference range for a premenopausal woman. If symptoms of estrogen imbalance (estrogen dominance and/or deficiency) are problematic, consider estrogen therapy (if estradiol is low and patient is > 40 y/o) and/or progesterone therapy (if estradiol is low-normal or high).

TESTOSTERONE is within range and symptoms of androgen imbalance are minimal.

DHEAS is within normal range (see age-adjusted range graph). DHEAS rises rapidly from adolescence to late teens/early twenties and then steadily drops to the lower end of range by age 70-80. Low DHEAS may contribute to low androgen symptoms (decreased libido, depression, fatigue, memory lapses, and/or bone loss). In individuals with very low DHEAS , DHEA supplementation in the 5-25 mg dosing range or use of adrenal adaptogens may effectively raise DHEAS to levels seen in mid-life. If low-dose DHEA therapy does not increase DHEAS this may be due to differences in the delivery (oral, topical, vaginal). Oral DHEA passes through the gut and liver where it is extensively metabolized by sulfation to DHEAS. Topical and less so vaginal delivery of DHEA result in much less DHEAS, but significant increase in circulating levels of DHEA, which is more likely to be metabolized to downstream androgens (androstenedione, testosterone) and estrogens (mostly estrone, but to some extent estradiol).

CORTISOL (4x diurnal immunoassay) is within normal range throughout the day but drops to a low level at night, indicating low adrenal reserve and HPA axis dysfunction. This usually is caused by stressors, a cortisol precursor deficiency (pregnenolone and progesterone), and/or nutritional deficiencies (low vitamins C and B5, low protein diet). The most common stressors that can cause adrenal exhaustion include: psychological stress (emotional), sleep deprivation, physical insults (surgery, injury, diseases), chemical exposure (environmental pollutants, excessive medications), and pathogenic infections (bacterial, viral, fungal). Depletion of cortisol by a chronic stressor often leads to symptoms

such as fatigue, allergies (immune dysfunction), chemical sensitivity, cold body temp, and sugar craving. Adequate sleep, gentle exercise, naps, meditation, proper diet (adequate protein), natural progesterone, adrenal extracts, herbs, and nutritional supplements (particularly vitamins C and B5) are some of the natural ways to help support adrenal function (consult with a health care provider for proper types and dosing). For additional information about strategies for supporting adrenal health and reducing stress(ors), the following books are worth reading: "Adrenal Fatigue", by James L. Wilson, N.D., D.C., Ph.D.; "The Cortisol Connection", by Shawn Talbott, Ph.D.; "The End of Stress As We Know It" by Bruce McEwen; "Awakening Athena" by Kenna Stephenson, MD.