TEST REPORT

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Beaverton, OR 97008
Phone: 503-466-2445 Fax: 503-466-1636

ZRT LABORATORY

 # D2026 05 07 169 S

Ordering Provider:
Getuwell

Samples Received
05/07/2026

Report Date
05/14/2026

Samples Collected
Saliva - 05/04/26 06:10
Saliva - 05/04/26 06:45
Saliva - 05/04/26 07:15
Saliva - 05/04/26 12:05
Saliva - 05/04/26 19:00
Saliva - 05/04/26 22:30

Patient Name: Saliva Cortisol Awakening Response
Patient Phone Number:

Gender	Last Menses	Height	Waist
Female	05/01/2026	5 ft 6 in	29 in
DOB	**Menses Status**	**Weight**	**BMI**
1/1/1972 (54 yrs)	Pre-Menopausal	152 lb	24.5

TEST NAME	RESULTS | 05/04/26	RANGE
Salivary Steroids & Other Analytes (LC-MS/ECLIA)		
DHEAS	1.31	1.08-8.33 ng/mL
Cortisol	6.5	2.88-7.12 ng/mL (morning)
Cortisol	11.1 H	2.88-7.12 ng/mL (morning)
Cortisol	6.1	2.88-7.12 ng/mL (morning)
Cortisol	1.0 L	1.11-2.74 ng/mL (noon)
Cortisol	1.7 H	0.61-1.33 ng/mL (evening)
Cortisol	0.5	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

oral Ethinyl Estradiol + Norgestimate (Pharmaceutical) (1 Days Last Used)

David T. Zava, Ph.D.
Laboratory Director

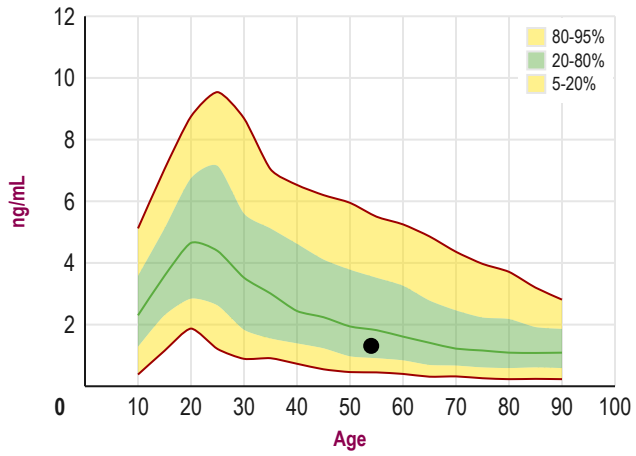
Alison McAllister, ND.
(Ordering Provider unless otherwise specified on page 1)

Graphs

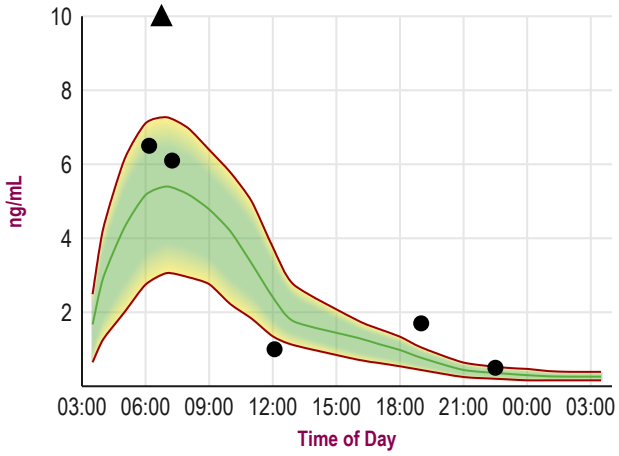
Disclaimer: Graphs below represent averages for healthy individuals not using hormones. Supplementation ranges may be higher. Please see supplementation ranges and lab comments if results are higher or lower than expected.

Average ▼▲ Off Graph

Saliva DHEAS



Saliva Cortisol



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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 | 05/04/26
Estrogen / Progesterone Deficiency	4%
Estrogen Dominance / Progesterone Deficiency	3%
Low Androgens (DHEA/Testosterone)	6%
High Androgens (DHEA/Testosterone)	17%
Low Cortisol	5%
High Cortisol	10%
Hypometabolism	2%
Metabolic Syndrome	18%

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			

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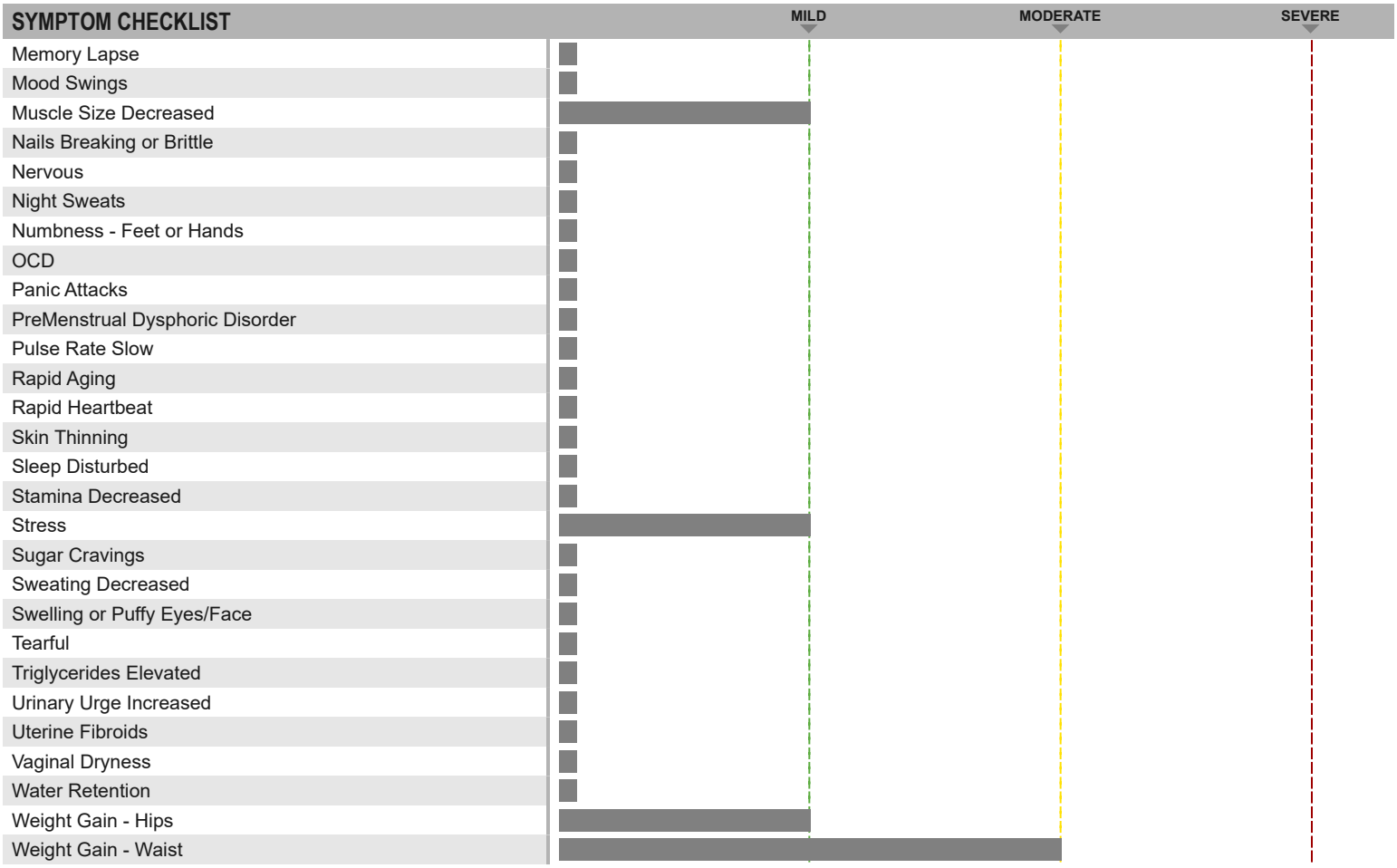

Lab Comments

DHEAS is within low-normal expected age range. Chronic low DHEAS may suggest HPA axis dysfunction, particularly if cortisol is also low and symptoms are indicative of low adrenal function. DHEAS is highest during the late teens to early twenties (10-20 ng/ml) and drops steadily with age to the lower end of range by age 70-80. Consider adrenal adaptogens or DHEA supplements if symptoms of androgen deficiency are problematic.

CORTISOL (6x diurnal immunoassay) is within high-normal reference range in the first morning cortisol, rises to a high level within 30 minutes, and is maintained at a high-normal level at 1 hr post awakening. These results demonstrate a healthy Cortisol Awakening Response (CAR) over the first three morning saliva collections. Cortisol then drops to within low-normal range about noon, rebounds to a slightly elevated level in the evening and then returns to normal level at night. A healthy CAR should start with low-normal levels of cortisol in the first collection, increase and peak within 30 minutes, and then begin to taper by about 1 hour. Cortisol should then follow the expected circadian rhythm and continue to drop to a nadir by night before bed, as seen in this individual's results.

A high-normal first morning cortisol might indicate that cortisol was already increasing prior to awakening due to excessive stressors at that time of day. Higher cortisol levels before and after the 30 minute peak is not considered a normal CAR and may indicate excessive stressors before and after awakening. Following the high CAR, cortisol levels drop to within normal levels the remainder of the day.

Chronic high cortisol is often caused by stressors that signal the brain-adrenal axis to synthesize cortisol. The most common stressors that raise cortisol are psychological stress (emotional), dysglycemia (low blood glucose), physical insults (surgery, injury), diseases (cancer, diabetes), environmental pollutants, excessive medications, and pathogenic infections (bacteria, viruses, fungi, parasites). Persistent high cortisol, particularly if it occurs in the evening/night, can eventually cause excessive breakdown of normal structural tissues (muscle wasting, thinning of skin, bone loss) and immune suppression.

Symptoms commonly seen with high cortisol include sleep disturbances, vasomotor symptoms (hot flashes and night sweats, despite normal or high estrogen levels), fatigue, depression, and nervous anxiety. High cortisol also can impair the actions of other hormones such as insulin and thyroid, causing symptoms of their deficiency even though the levels of these hormones may be within normal range (i.e., insulin resistance and thyroid deficiency). If symptoms of cortisol imbalance are problematic, as self-reported, consider adrenal support.

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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; "The Gospel of Women's Health" by Kenna Stephenson, MD; "The Role of Stress and the HPA Axis in Chronic Disease Management" by Thomas Guilliams, PhD.

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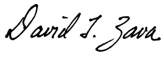

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