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Disclaimer

The information provided here is for informational and educational purposes only. It is not intended as medical advice or for therapeutic purposes. Any discussion of therapy is intended only for purposes of illustration and example and not as a therapeutic guide for any specific individual. Consult with your physician prior to considering any therapies.

How common are hormonal problems?

- Most patients have at least one symptom that may relate to hormonal imbalance.
- Most doctors *don't recognize these symptoms as being hormonal in origin*

Examples of typical symptoms with hormonal implications

- Low body temperature
- Fatigue
- Immune dysfunctions
 - Infections
 - Allergies
 - Autoimmune Dz
- Digestive problems
 - Acid reflux
 - Poor digestion
 - Gas/bloating
- Anxiety
- Depression
- Insomnia/Narcolepsy
- Blood pressure
- Headaches
- PMS
- Sexual dysfunctions
- Hair loss
- Weight problems
- Cold extremities

- 👉 **Your best physician is you**
- 👉 **The medical professional is your consultant**
- 👉 **If the above is forgotten, *you're* the one in trouble**

Adrenal-Thyroid-Ovary Connection

- These three all affect each other.
- Estrogen & Progesterone balance
- Thyroid & Adrenal balance

Adrenal Physiology - Structural / Chemical

- **Location**
 - Rests upon the kidney
 - 3 Glands in 1
- **Many hormones produced including: cortisone, adrenaline, mineral corticoids, sex hormones/
Pregnenolone/DHEA**

Adrenal Physiology - Functional

- *The main job of the adrenals is to deal with stress.* This means dealing with changes (adaptation) as well as any threat to our survival.
- Dealing with any stress depletes its hormonal or functional reserve and ability to handle other stress
- Maintains
 - Stability
 - Centeredness/grounding



What is **Stress**?

Stress is *anything that threatens our*

Existence

Survival

Security

Joy

Ability to thrive

Stability or Centeredness

Or, requires *adaptation* (emotional, social, thermal, hormonal, chemical, physical etc.)

Inverse Relationship Between Thyroid and Adrenals:

Patient presentation → appearance,
chemical, structural,
immunological, emotional and
functional

A *'low'* in one usually looks
like a *'high'* in the other

Inverse Relationship Between Estrogen and Progesterone:

Patient presentation → appearance,
chemical, structural,
immunological, emotional and
functional

A *'low'* in one usually looks
like a *'high'* in the other

Inter-relationship of Adrenals-Thyroid-Ovaries

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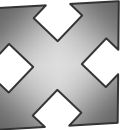
A low 'one' looks/acts like a high 'other'

**Adrenal
function**



**Thyroid
function**

**Proges-
terone**



Estrogen

A low 'one' looks/acts like a high 'other'



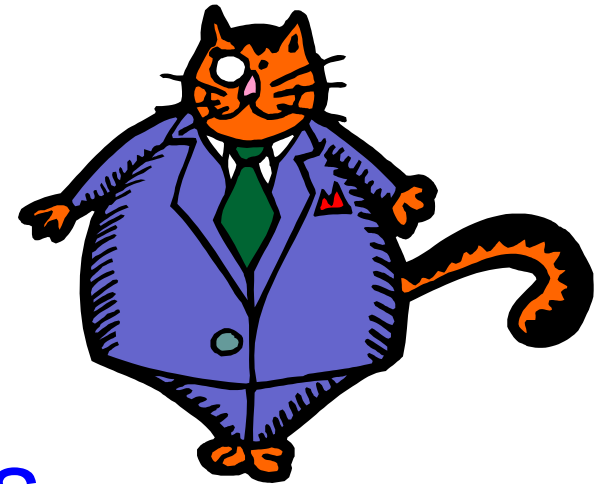
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Why the confusion?

The vast majority of low thyroid conditions are accompanied by stressed adrenals. If the adrenal problem isn't recognized, the symptoms tend to be attributed to thyroid alone. In a *purely* thyroid or a *purely* adrenal condition, the differences become apparent.

The ('pure') Hypothyroid Patient

- *Warm* hands, poor *heat* tolerance
- Low, *stable* body temp
- Heavy Build
- Rubor
- Sparse Outer Eyebrows
- Slower Moving (vs. nervous types)
- Puffy Around the Eyes
- Coarse Hair



The 'pure' Hypoadrenal patient

- *Cold* hands/feet, poor *cold* tolerance
- Low, unstable temp
- Pallor
- Fine, Thinning Hair
- Hollow eyes and thick eyebrows
- Thin build
 - Ectomorphic vs. Mesomorphic
 - Women: Often flat-chested, mitral valve prolapse (weakly supported valve, weak connective tissues)
 - Men: Thin, joint injury prone, flat feet



Comparison of Characteristics of Low Adrenal ↔ **Low Thyroid**



Thyroid-Adrenal Comparison

Typical Symptoms

Low Thyroid

Low Adrenal

- Appearance: Heavy, red Thin, pale
- Mood: Stable Unstable
- Mood: Depression Anxiety
- Immune: Hypo-reactive Hyper-reactive
- Immune: Infections Allergies
- Lipids: High Low
- Intolerance: To heat To cold
- Hands/feet: Warm Cold

Thyroid and Adrenal Comparison

Weak thyroid or strong adrenals

- Heavy build(fat? or stocky?)
- Rubor (rosy)
- Hypo-reactive
 - Slow, doesn't excite easily(calm or just slow?)
 - Immune: Infections
- Mental/Emotional
 - Depression
 - Calm
- Deep sleeper or narcolepsy

Excess thyroid or weak adrenals

- Thin build
- Pale
- Hyper-reactive
 - Jumpy, nervous, startles or excites easily
 - Immune: Allergies, Autoimmune
- Mental/Emotional
 - Anxiety, Panic Attacks
 - Nervousness
- Light sleeper or insomnia

Thyroid and Adrenal Comparison (con't)

Weak thyroid or strong adrenals

- Cholesterol high / HDL low
- Serum: Na^+ \uparrow , low K^+ \downarrow
- CBC: WBC \uparrow Platelets \uparrow
- Retains fluid, wet, good secretions
- Thinned out outer eyebrows
- Thick, coarse, curly hair
- Eyes full or puffy
- Tunnel vision or laser focus

Excess thyroid or weak adrenals

- Cholesterol low / HDL high
- Serum: Na^+ \downarrow , K^+ \uparrow
- CBC: WBC \downarrow Platelets \downarrow
- Can't hold fluid, dry, poor secretions
- Full, thick eyebrows
- Thin hair, straight
- Eyes hollowed out or bulging
- Wide radar or intuitive

Thyroid and Adrenal Thermal Comparison

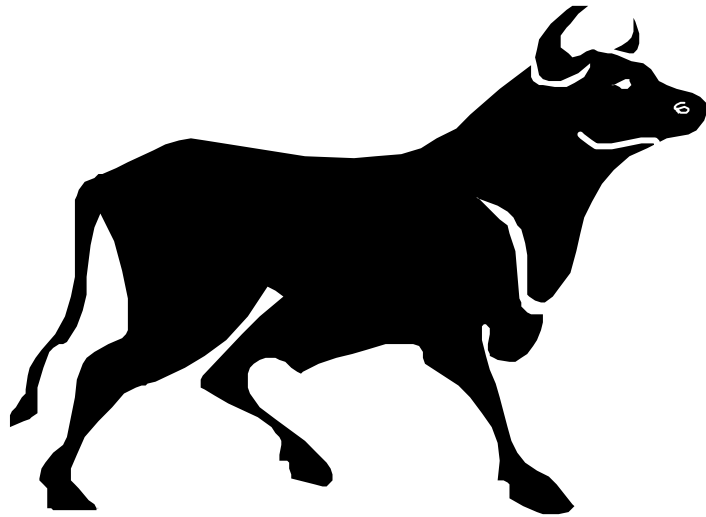
Hypothyroid

- Does not tolerate heat
- Low core temp → *stable*
- Hands warm (in pure hypothyroid)

Hypoadrenal

- Does not tolerate cold
- Low core temp → *unstable*
- Hands cold (in pure and mixed)

Strong and Weak Adrenals OR The Bulls and the Butterflies



Adrenals: Typical Characteristics of Weak (Butterfly) vs Strong (Bull)

Typical Characteristic	Weak Adrenals (Butterflies)	Strong Adrenals (Bulls)
Gender	Female	Male
Skin Tone	Light	Dark
Fluids: skin, secretions, bowels	Dry: can't hold on to water, poor secretions, constipated	Moist: good secretions, diarrhea
Blood Type	A	O
Constitution	Delicate / Ectomorphic	Resistant / Mesomorphic
Perseverance: Physical / Mental	Poor	Strong
Alcohol/Drugs or Supplements	Handles Poorly	Handles Well
Startle Tendency	Startles Easily	Normal Startle

General Principles of Treatment

- Remove the impediments to proper function
 - Replacement of Nutritional Deficiencies
 - Removal of Stresses
 - Physical, Chemical, Emotional
 - Hormonal (e.g. hyper- or hypothyroidism)
 - Removal of Toxins

General Principles of Treatment (cont.)

- Oxygenation
 - Thoracic/Rib Adjustments, Postural Correction
 - Environment/location
 - Supplements (e.g. Co Q 10)
- Rest and Sleep

General Principles of Treatment (cont.)

- Support the Body's physiology and healing process or efforts
 - Nutritional (whole or real food)
 - Endocrine/Hormonal support
 - Glandular extracts (thyroid/adrenal, etc.)
 - Rx (natural) hormone replacement as needed
 - Herbs to suppress or support glandular functions
 - Iodine: can help if thyroid weak, hurt if thyroid is 'hyper'

Estrogen Dominance

Estrogen dominance is a condition in which a woman can have *excessive, normal, or deficient* levels of estrogen, but has *too little progesterone to balance the estrogen level. It means a **predominance** of estrogenic effect as opposed to progesterone effects.*

Estrogen Dominance

The balance between the estrogen and progesterone matters more than how much (of these) we have. A woman can have a low estrogen but a lower progesterone (re. effects) and be estrogen dominant.

Inter-relationship of Adrenals-Ovaries-Thyroid

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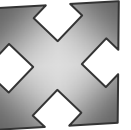
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**Adrenal
function**



**Thyroid
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**Proges-
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Estrogen

A low 'one' looks/acts like a high 'other'



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Estrogen Dominance Symptoms

Anxiety, irritability, anger, agitation,
Cramps, heavy bleeding, prolonged
bleeding, clots
Water retention/weight gain, bloating
Breast tenderness, lumpiness,
enlargement, fibrocystic breasts
Mood swings, depression, weepiness
Headaches/migraines
Food cravings, sweet cravings,
chocolate cravings
Muscle pains, joint pains, back pain
Acne
Foggy thinking, memory difficulties
Fat gain, especially in abdomen, hips
and thighs
Cold hands and feet (i.e., stressed
adrenals)

Irregular periods
Problem with sex drive: decreased,
excessive, or fluctuating
Gall bladder problems
Infertility
Insomnia
Osteoporosis
Endometriosis
Polycystic ovaries
Uterine fibroids
Cervical dysplasia (abnormal cells on
PAP smear)
Allergic tendencies.
Autoimmune disorder
Breast, uterine, cervical, or ovarian Ca.
Blood sugar instability, Insulin Resistance

Estrogen-Progesterone Relationship

Like dancing partners, the relationship can be opposite or complimentary

Function/Tissue	<u>Estrogen</u>	<u>Progesterone</u>
Sleep	Insomnia	Sleep
Mood	Agitation	Calm
Mood	Weepy	Stable mood
Mind	Poor focus/ overactive	Focused, calm
Cellular Proliferation (division)	Increased in cervical, uterus, breast	Decreased
Fatty Tissue	Increased	Estrogen effect blocked
Bone	Decreases Loss	↑ Build up

Overview

Balance with other Hormones: E.D.

- Estrogen Dominance is usually due to a deficit of progesterone. Correcting this greatly facilitates adrenal repair since progesterone supports adrenal function.
- Conversely, strengthening the adrenals helps correct E.D.

Estrogen Dominance is Very Common
Most women today have
estrogen dominance. It
ranges from mild to severe.
When its noticeable for a
short time, the condition is
called *PMS*

Common causes of Estrogen Dom.

- **Stress** (excess cortisol displaces progesterone)
- **Xenohormone** exposure
- Use of oral or injected **contraceptives**
- **Conventional HRT** (using horse hormones and/or synthetic/non—bio-identical hormones)
- **Adrenal Fatigue**
- **Poor diet** (usually high in carbs, low fat)
- Consumption of **trans-fats**
- Nutritional **deficiencies** (esp. Mg, Zn, Cu , B's)
- **Luteal Insufficiency** (low ovarian progesterone production)
- **Anovulatory cycles** (cycle/menstruation w/o ovulation, and therefore no ovarian progesterone is produced)
- **Obesity** (estrogen is made in the fat cells; excess fat cells make excess estrogen.)

Effect of Estrogens on thyroid

- Can mimic hypothyroidism (fat deposit, fluid retention)
- Can mimic thyroid function (agitation, insomnia...)
- Thyroid Lab testing: Raises TBG (the protein reservoir in the blood which binds to T4 and T3) thus raising the Total T4 and Total T3 levels (producing an artifact that looks like the thyroid level is higher than it actually is). Free T3 and Free T4 and unaffected.

British Medical Journal Article... (TSH >2.0, assoc. w/ Hypothyroidism)

Dr. A P Weetman, professor of medicine, wrote in the article "Fortnightly review: Hypothyroidism: screening and subclinical disease," which appeared in the 19 April 1997 issue of the *British Medical Journal*, the following groundbreaking statement...

British Medical Journal Article (cont)

". . . even within the reference range of around 0.5-4.5 mU/l, a high thyroid stimulating hormone concentration (>2 mU/l) was associated with an increased risk of future hypothyroidism. The simplest explanation is that thyroid disease is so common that many people predisposed to thyroid failure are included in a laboratory's reference population, which raises the question whether thyroxine replacement is adequate in patients with thyroid stimulating hormone levels above 2 mU/l."

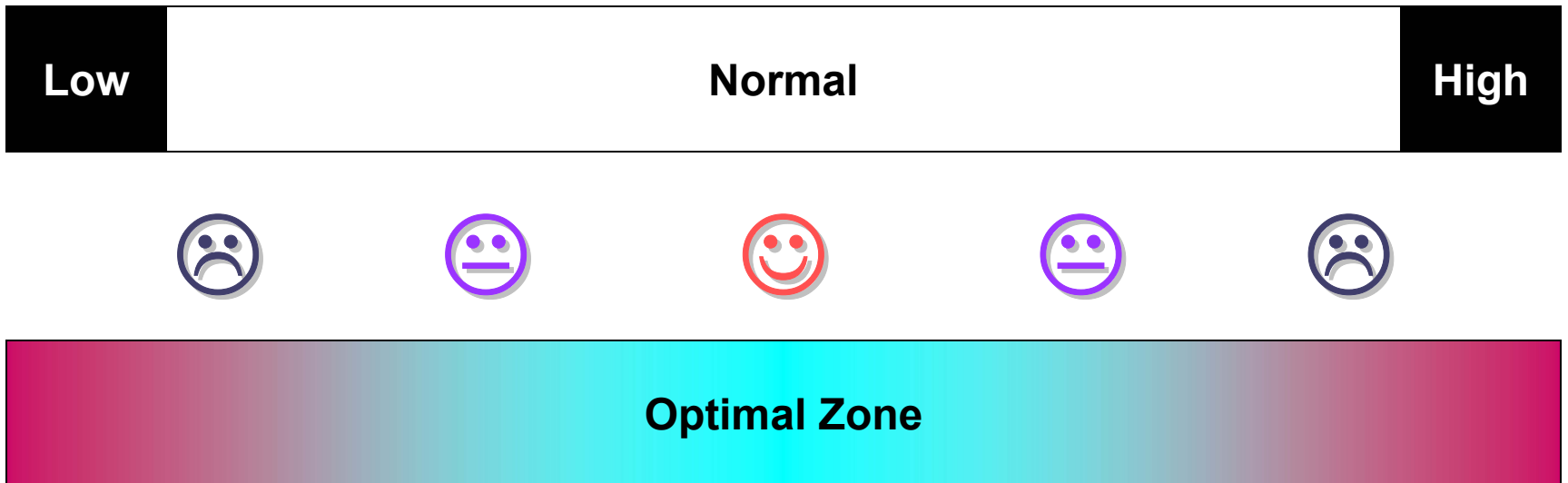
4 yrs after the BMJ article...(cont)

In what constitutes a fairly dramatic reversal of its previous doctrine regarding how hypothyroidism should be diagnosed, the American Association of Clinical Endocrinologists (AACE) has said in its January **2001** Thyroid Awareness Month materials that a "TSH level between 3.0 and 5.0 uU/ml ...should be considered suspect."

On March 2003...

AACE (American Association of Clinical Endocrinologists) revised its position and stated that the new normal values for TSH should be between 0.3 and 3.0

Normal vs. Optimal

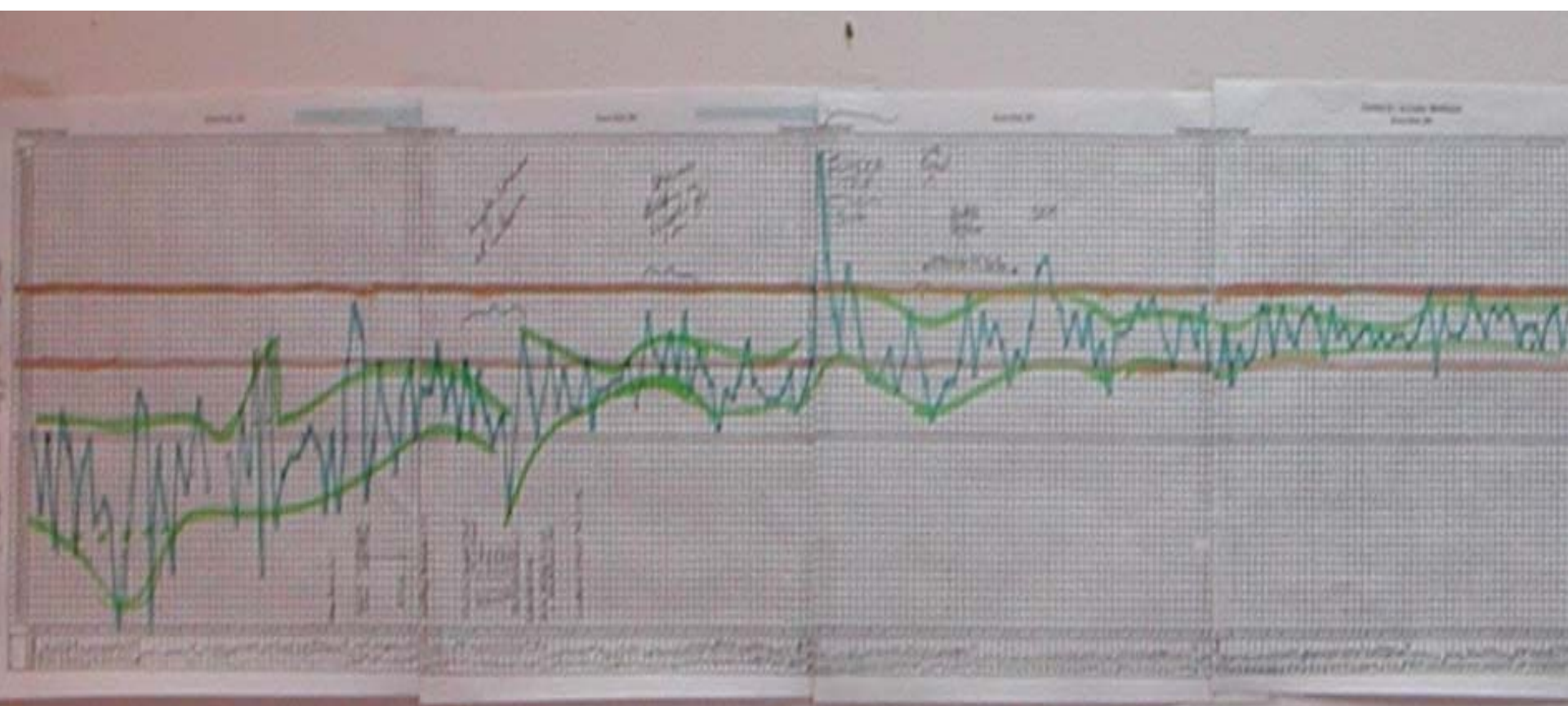


Thyroid Scale Diagram

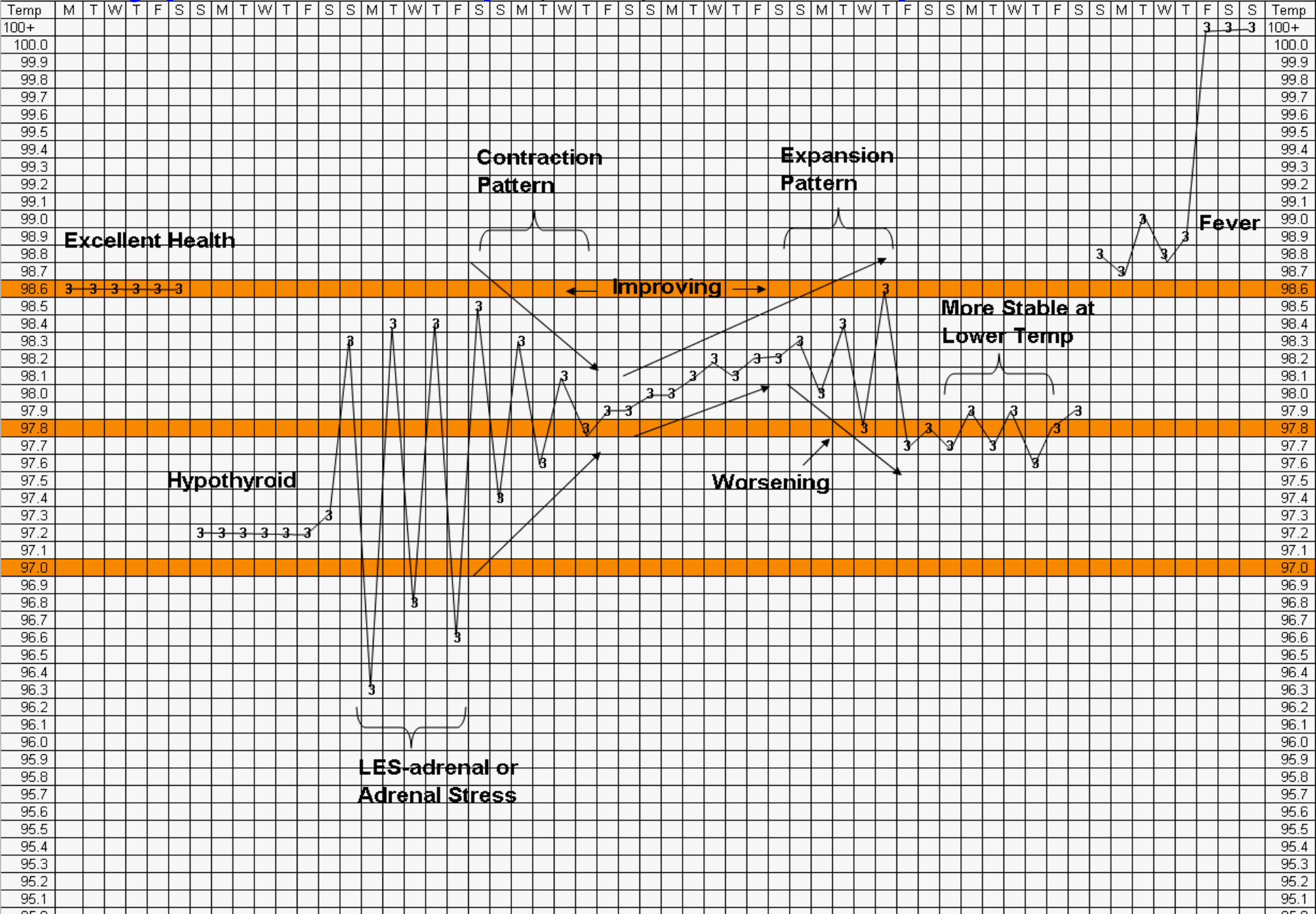
- Plots TSH, T4, and T3 values on a relative scale
- Values are viewed relative to *optimal* rather than *normal*
 - optimal is (usually) roughly the midpoint of the normal range for the T3 and T4 but 1-2 (or 1.3-1.8) for the TSH
 - goal is to be optimal
- Values are viewed relative to one another
 - TSH Feedback
 - T4 conversion to T3 and RT3
- Available on www.DRRIND.com

(continued) Role of the Pituitary

- Decides how much energy to produce by generating TSH (based on T4 and/or T3 → need, availability, and tolerance)
- The more TSH in circulation, the more the thyroid gland generates T4



Typical Temperature Graph Patterns



Common Thyroid Tests

- Thyroid Stimulating Hormone (TSH)
- T-3 Uptake (T3U)
- Free T-3 (FT3) and Free T-4 (FT4)
- Total T-3 (TT3) and Total T-4 (TT4)

Interpretation of Thyroid Lab Tests



- **TSH (Thyroid Stimulating Hormone)** → A hormone secreted by the pituitary gland whose functions it is to signal the thyroid gland to make a thyroid hormone (called thyroxine or T4). TSH represents the 'desire of the pituitary' for thyroid hormone. Thus a high TSH means the pituitary wants more thyroid hormone (T4 or T3). The pituitary senses
 - The available level of thyroid hormones (T4 and T3)
 - The body's need for thyroid hormones
 - The body's (usually the adrenal gland's) ability to handle thyroid hormones
 - The end result of this evaluation is the TSH which is the expression of this need.
- **T4** → This is the 'pro-hormone' that is either made by the thyroid gland or taken in as a pill. It is a pro-hormone because it doesn't do anything on its own but will become either a stimulant to energy production (T3) or inhibitor to the energy production (RT3)
- **T3** → The 'business end' of thyroid hormone production. It generates energy (in the form of ATP). Normally, the amount of T3 is the same (in a relative sense) as T4. A healthy person has mid-range values of T4 and T3 (according to the scale the particular lab is using). A T3 that is relatively lower than the T4 is a sign that the body is holding back on making T3 from T4 and usually occurs when the body is putting the brakes on energy production such as occurs in weak adrenals because the adrenals are unable to handle all the metabolic energy coming at them. The opposite occurs when the body either needs more energy (e.g., fever) or is able to utilize more energy (e.g., adrenals became healthier).

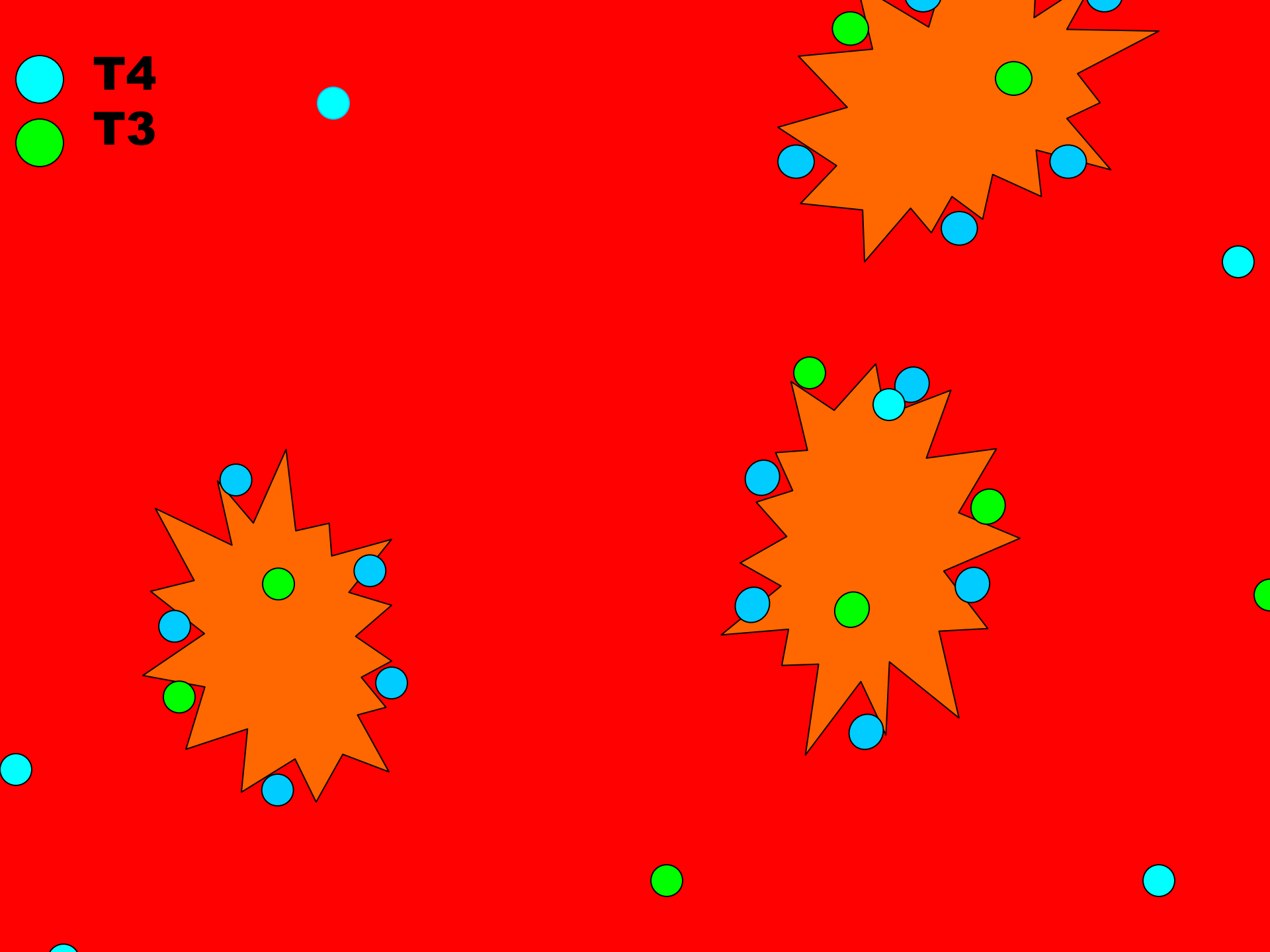
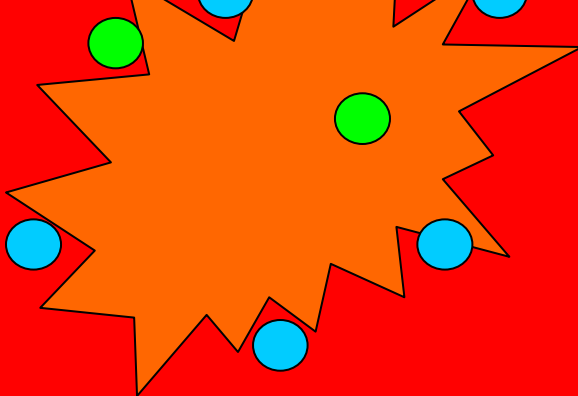
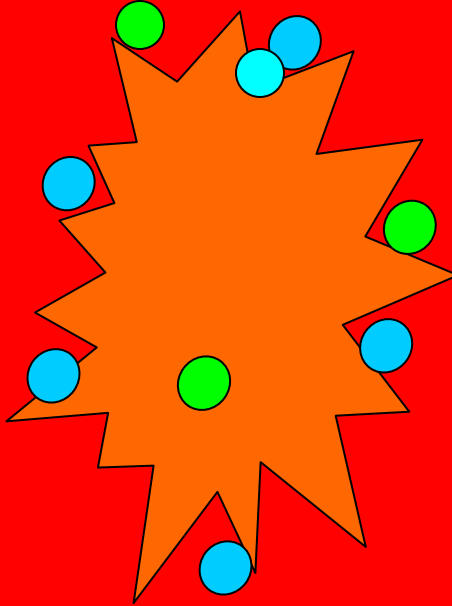
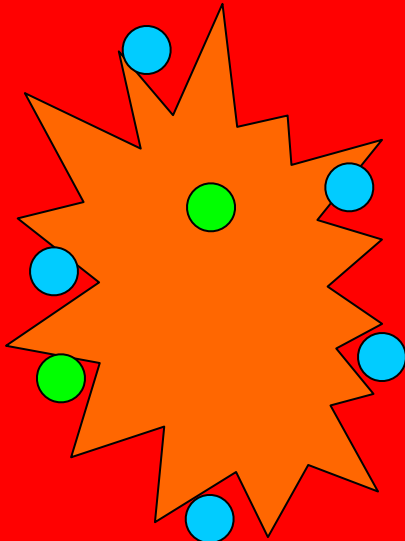
T-3 Uptake (T3U) - ~~AVOID!~~

- Indirect test used to measure 'T4'!
- Measures how saturated serum protein is
- The more it takes up, the less (one 'assumes') saturated with T4 it is and therefore we assume there is a low T4 level in the serum.
- Thus a high uptake means low T4 and a low uptake means high T4.
- It is an 'indirect' test that does not even measure T3. It is *almost* as accurate as a flip of a coin!

Free T3 and Free T4

- FT3 and FT4 measure the unbound (biologically active) levels of these hormones – It reflect the bio-available, not the total level of the hormones.

 T4
 T3



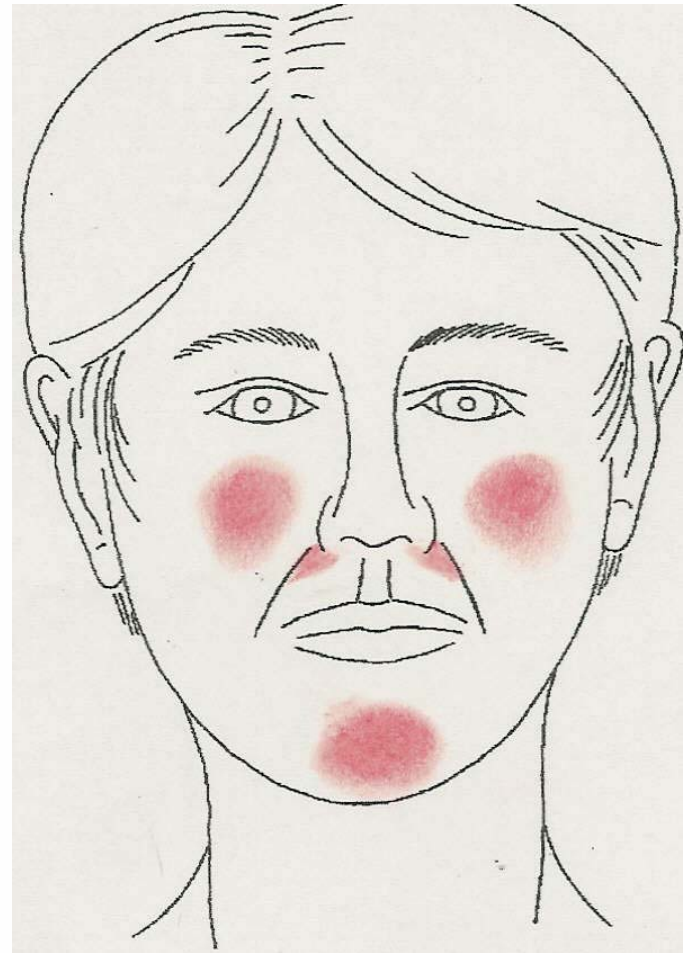
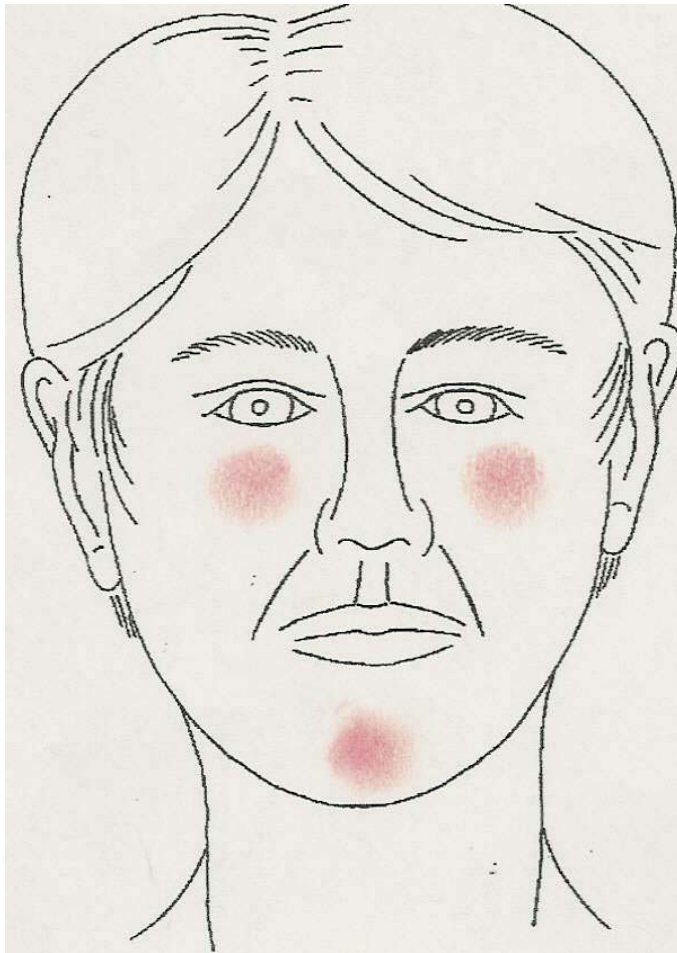
Total T3 and Total T4...

- TT3 and TT4 measure the total production of thyroid hormone, shows both the bound (inactive or stored) and unbound (biologically active/available) T4 and T3.

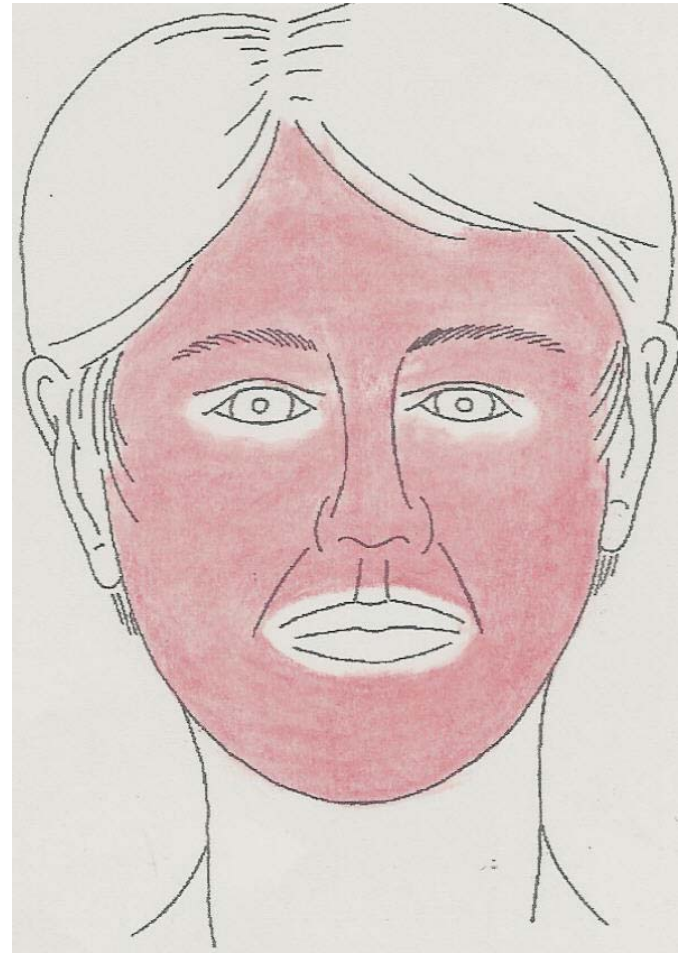
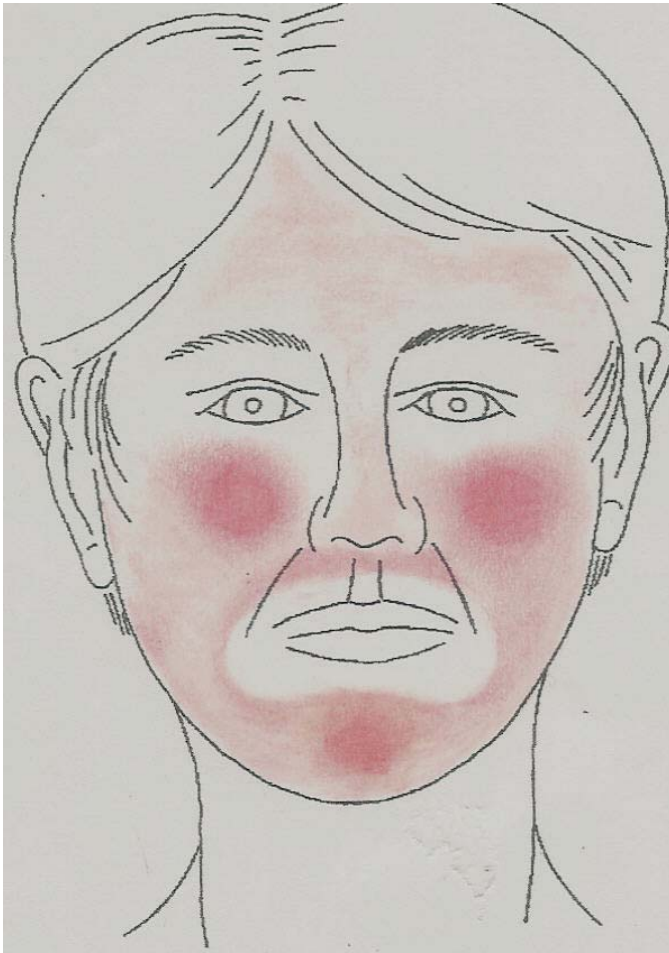
...Total T3 and Total T4

- Inaccurate in E.D. Thus it is often elevated in (estrogenic) women on BCP, HRT, and also in women who are pregnant. The estrogen effect increases serum proteins (TBG) and therefore the reservoir to which thyroid hormones are bound. Thus one can have a high (*protein bound*) TT3 with a much lower (*unbound*) FT3

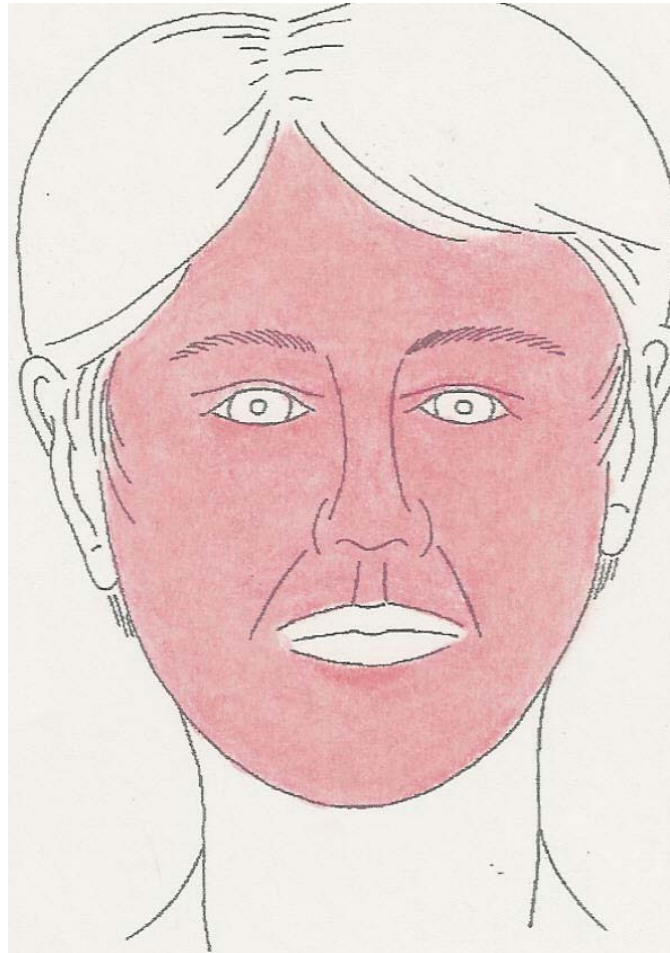
Perioral pink: 0% and 30%



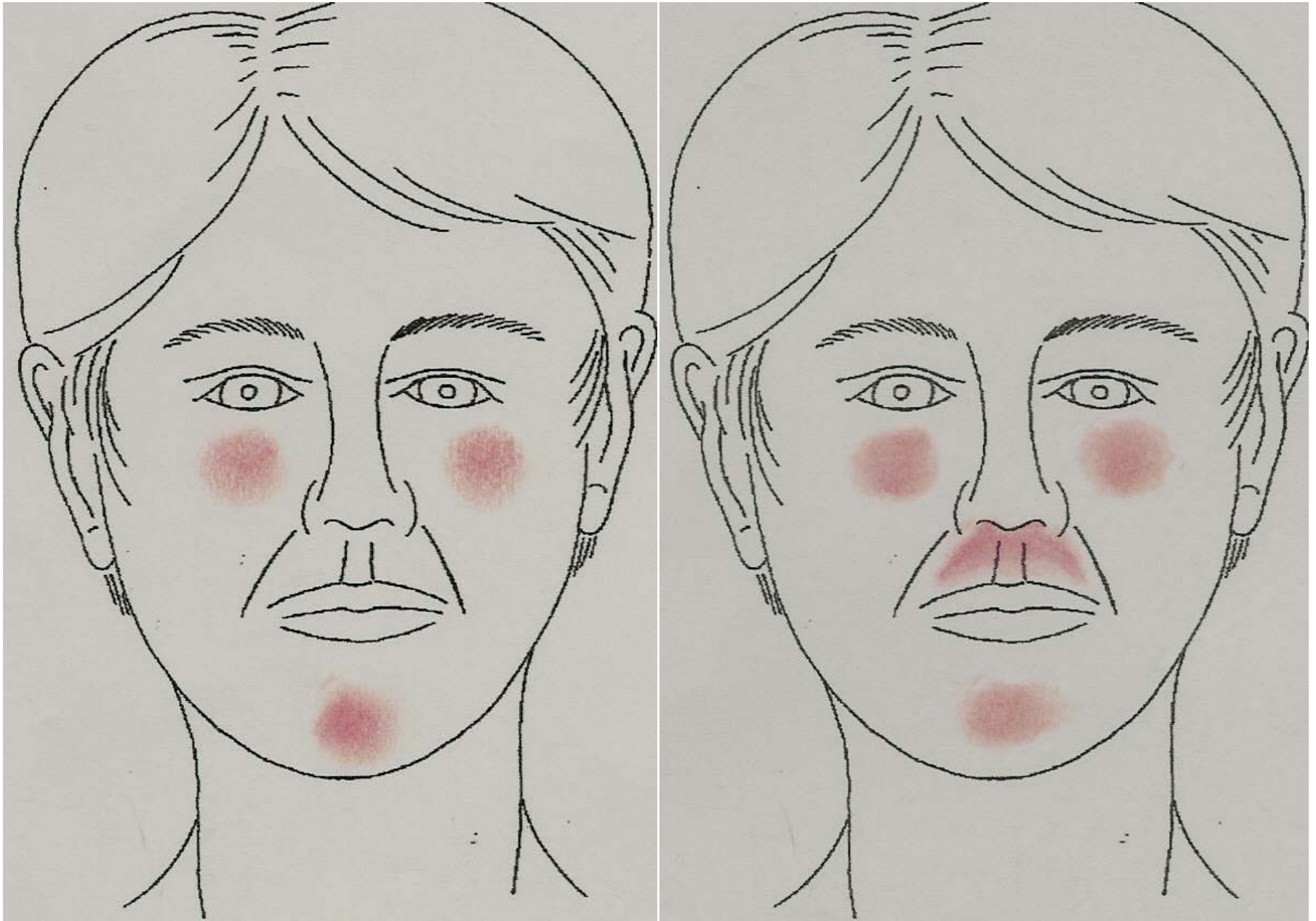
Perioral pink: 50% and 80%



Perioral pink: 100%



Perioral pink: 0% and 0% with sinusitis



20 yr old male, 70% pink. H/O Addison's: After 10 months Tx



← Unaltered photo

Enhanced contrast

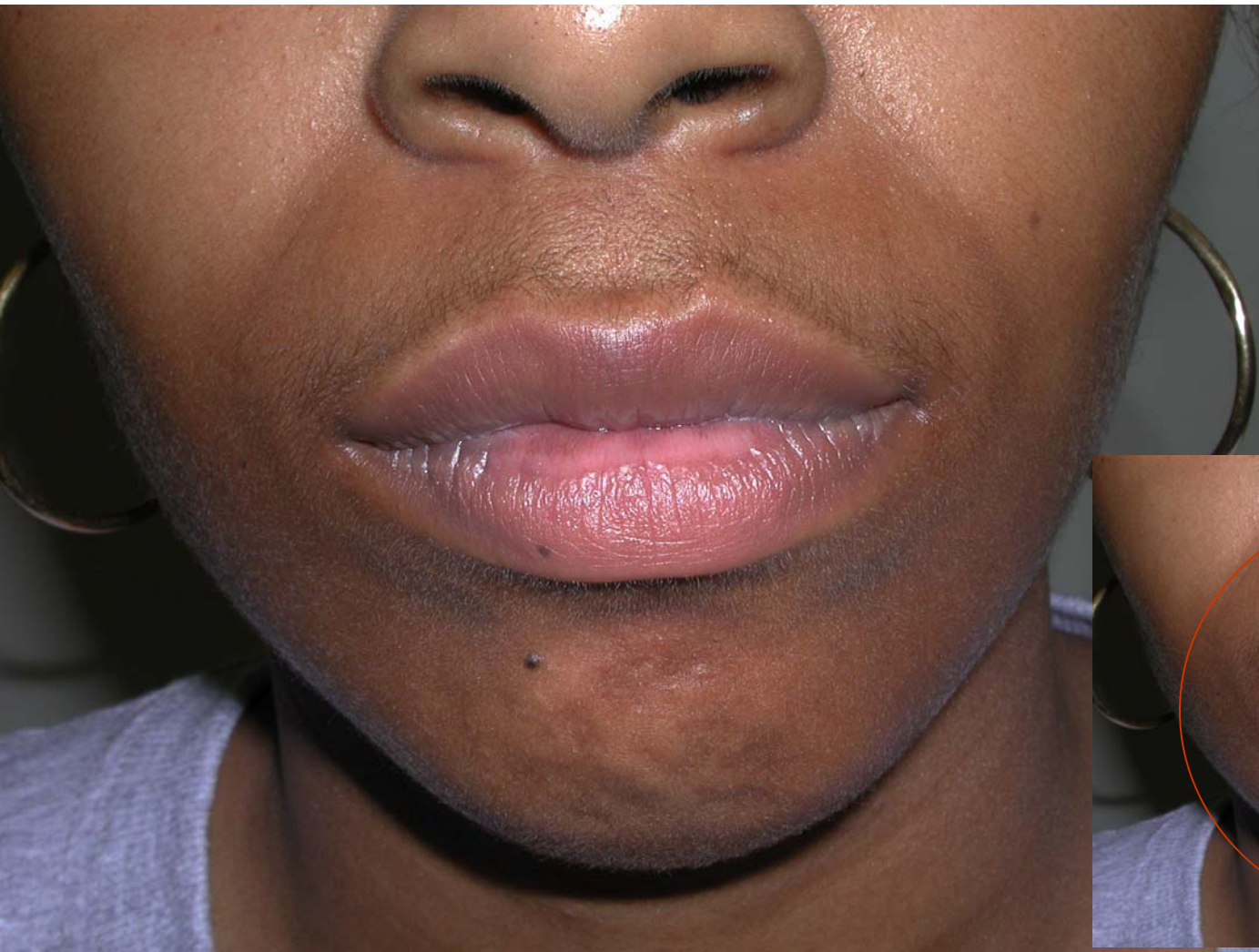


Pink →

Pale →

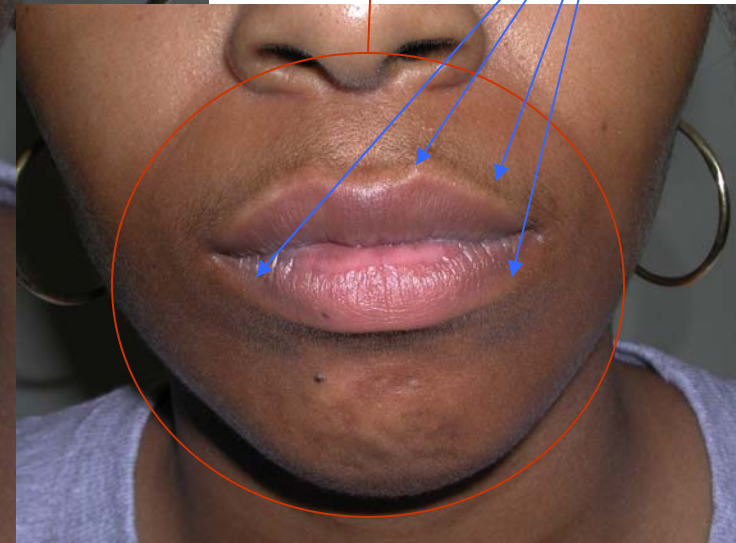
Pale →

Peri-oral shading in adrenal stress in people with dark skin

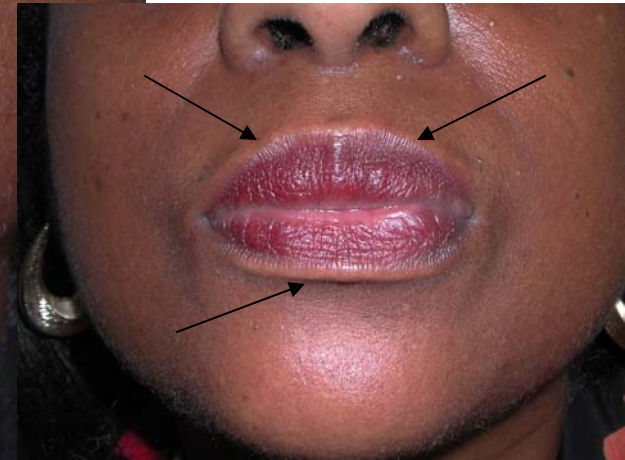


Dark shading

Pale outline
around lips



Adrenal stress: Dark skin → Pale outline around lips is common



Sinusitis Pattern

Zone of redness:

- Around nostrils
- Wedge



Mrs. J.

- 50% pink
- Wrinkles exist only in the pale zone
- Puckering the lips accentuates the color and the wrinkles



Mrs. J's finger/thumb prints: Shallow with cross creases



Looking at Finger Prints

- There is a correlation between Adrenal health and Connective tissue quality
 - Mesomorphs → strong adrenals
 - Ectomorphs → weak adrenals
- Connective tissue quality = collagen or tissue protein quality
- The protein quality in any part of the body reflects the rest of the proteins in the body

Fingerprints cont.

- The collagen/protein of the skin (skin/hair/nails) is easy to observe in looking at fingerprint quality
 - Depth and quality of the grooves
 - Deep → Shallow → Flat and shiny
 - Cross creases
- Color: Pink-Pale-Dusky
- Opacity: Opaque vs. Translucent (e.g., veins)

Good Fingerprints



Shallow Fingerprints & Cross Creases





Shallow, shiny fingerprints, mottled, thin 'transparent' skin with vein portions showing through

**Before Tx: Poor
connective Tissues**



**After 5 mos. of adrenal
repair (same pt.): Good
connective tissues**



**↑ Deeper Prints, less cross-
creasing, better color**

**← Dusky color, shallow/shiny
prints and cross-creases**

Adrenal **Do's**

and **Don'ts/Avoid**

Eat whole, healthy food	Junk food (→an oxymoron)
Drink water, herbal tea, veg. juices	Caffeine, alcohol, fruit juice
Eat fat (not oils) and protein	Sugars and (+/-) starches (especially w/o fat/protein)
Frequent meals (every 2-3H)	Skip meals, go hungry
Sleep (to bed early, same time, up without alarm clock)	Cut sleep, go to bed late, wake up to an alarm clock
Be in a clean environment	Toxic environment <i>or</i> people
Joy, comedies, hobbies	Work or relationship you hate
Pace your exercise, mild to moderate	Avoid excessive exercise leading to temp drop or subsequent fatigue

1→Crutch: Immediate (or short term)
The immediate replacement of hormones the adrenals can't adequately make. This gives an immediate lift by removing some of their burden and providing the rest of the body with support. An example of this is desiccated adrenal (glandular), DHEA, Pregnenolone, 7-Keto DHEA, Cortisol (or Licorice which helps maintain higher cortisol levels by interfering with the destruction of existing cortisol)

2→Facilitate: Intermediate We can 'grease the wheels' and make it easier for the adrenals to do their job by supporting the adrenal gland's function with substances such as Amino Acids, Rhodiola, Ginseng, Cordyceps.

3→Rebuild: Long Term To help the gland repair itself, the body needs raw materials to rebuild itself and the damaged glands. These include amino acids (the stuff proteins are made of), healthy fats such as animal source [butter etc] and phosphatidyl choline vitamins and minerals. Also, it is imperative to stop the old habits that contributed to adrenal fatigue e.g., sleep, overwork, poor nutrition etc.

Principles of Thyroid Repair

- Understand the problem first
- Make sure the adrenals can tolerate the thyroid energy
- Give the body what it needs
 - If only T4 is missing, then just give T4
 - If conversion of T4 to T3 is poor, give support for this or use a thyroid support with T4 such as Armour Thyroid (80% T4, 20% T3) or small amounts of slow release T3 (from a compounding pharmacy).
 - Any support with T3 should be given as a 2x or 3x daily dosage, not once daily as T3 is short lived.

Principles of Thyroid Repair

- Check the thyroid levels (FT3,FT4,TSH) as often as needed (usually every 6 weeks) and keep adjusting the dosage as needed. In most cases, if the pituitary is working well, I try to keep the TSH between 1.3 and 1.8 for optimal function. Some doctors try to keep the TSH between 1 and 2.
- Its important to monitor the symptoms, not just the lab work. Some people feel best with a higher or lower TSH. Make sure the adrenals are tolerating the thyroid support.

Fixing Estrogen Dominance

Fixing the ED in Menopause

Replace Progesterone as needed:

May need estrogen as well as progesterone. For Progesterone alone can use capsules, Troches, or Cream. Each has Pros+Cons

Fixing the ED in Menopause

Progesterone will *temporarily* up-regulate (sensitize) the estrogen receptors.

Starting at a normal dose can create many estrogenic effects (breast tenderness, fluid retention, agitation, insomnia, depression etc) for 2-3 weeks.

To avoid this, start at a tiny dose (about 1mg) and build up over 2-4 weeks as tolerated. Benefits are then seen within 1-2 weeks without the estrogenic side effects.

Fixing the E.D. in Menopause

- If progesterone is needed, you can use Progesterone + Phytoestrogens or you can use Progesterone and a compounded Rx estrogen such as Biestrogen (Estriol + Estradiol).
- I no longer recommend Triestrogen as it is a little stronger but less safe as it is Biestrogen plus Estrone.

Fixing the ED in Menopause

When estrogen (hormone replacement) therapy is needed for menopausal symptoms such as,

- Hot flashes (estrogen level dips)
 - Dry, thin, brittle/painful vaginal mucosa
 - Urinary stress incontinence due to poor pelvic muscle tone from low estrogen levels
- we can support with bio-identical estrogen replacement (don't confuse the bio-identical with the synthetic hormone analogs)

**Estrogen Dominance - PMS
repair in cycling women**

Inter-relationship of Adrenals-Ovaries-Thyroid

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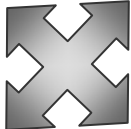
A low 'one' looks/acts like a high 'other'

**Adrenal
function**



**Thyroid
function**

**Proges-
terone**



Estrogen

A low 'one' looks/acts like a high 'other'



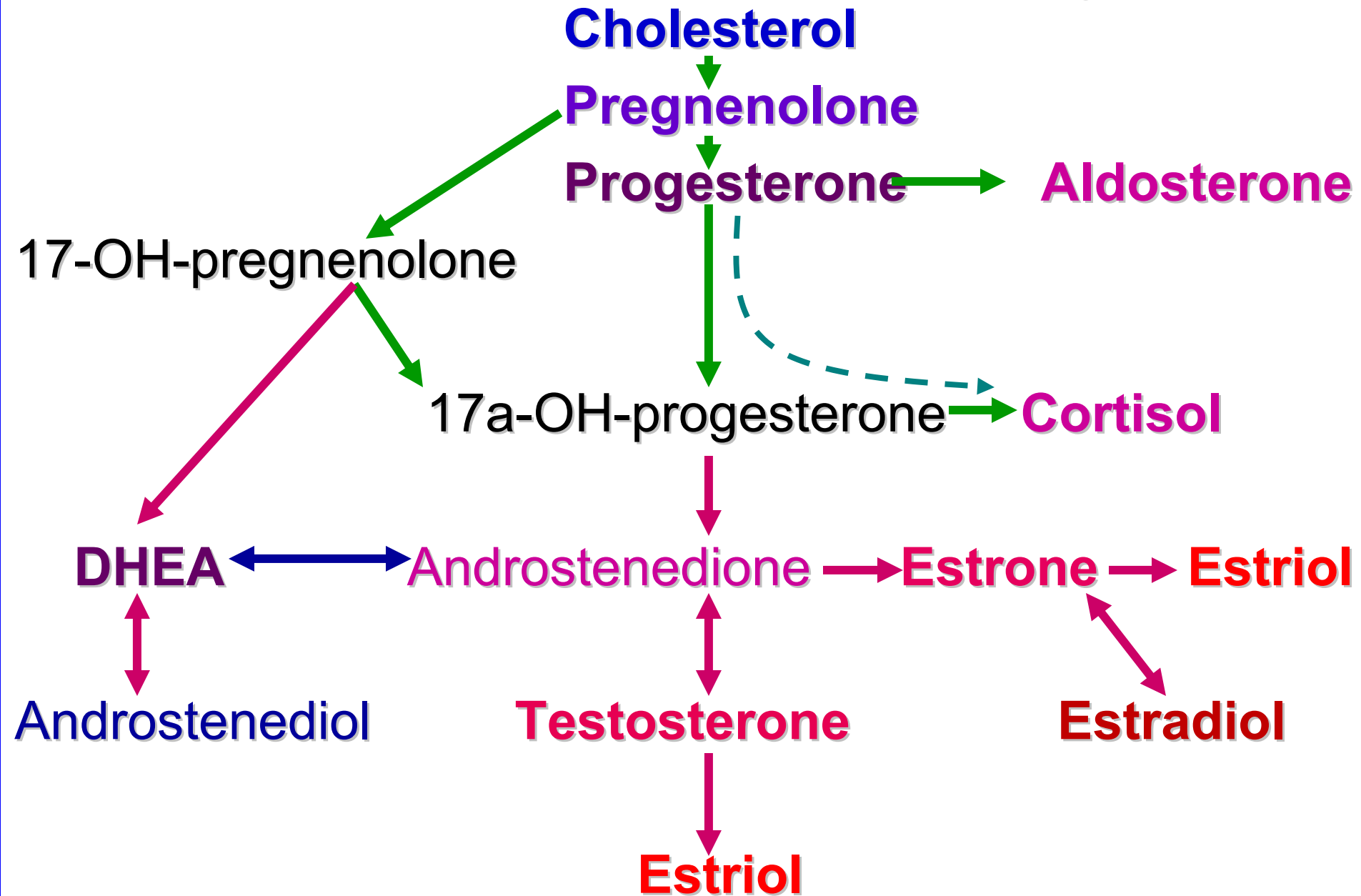
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Effect of Adrenals on Progesterone

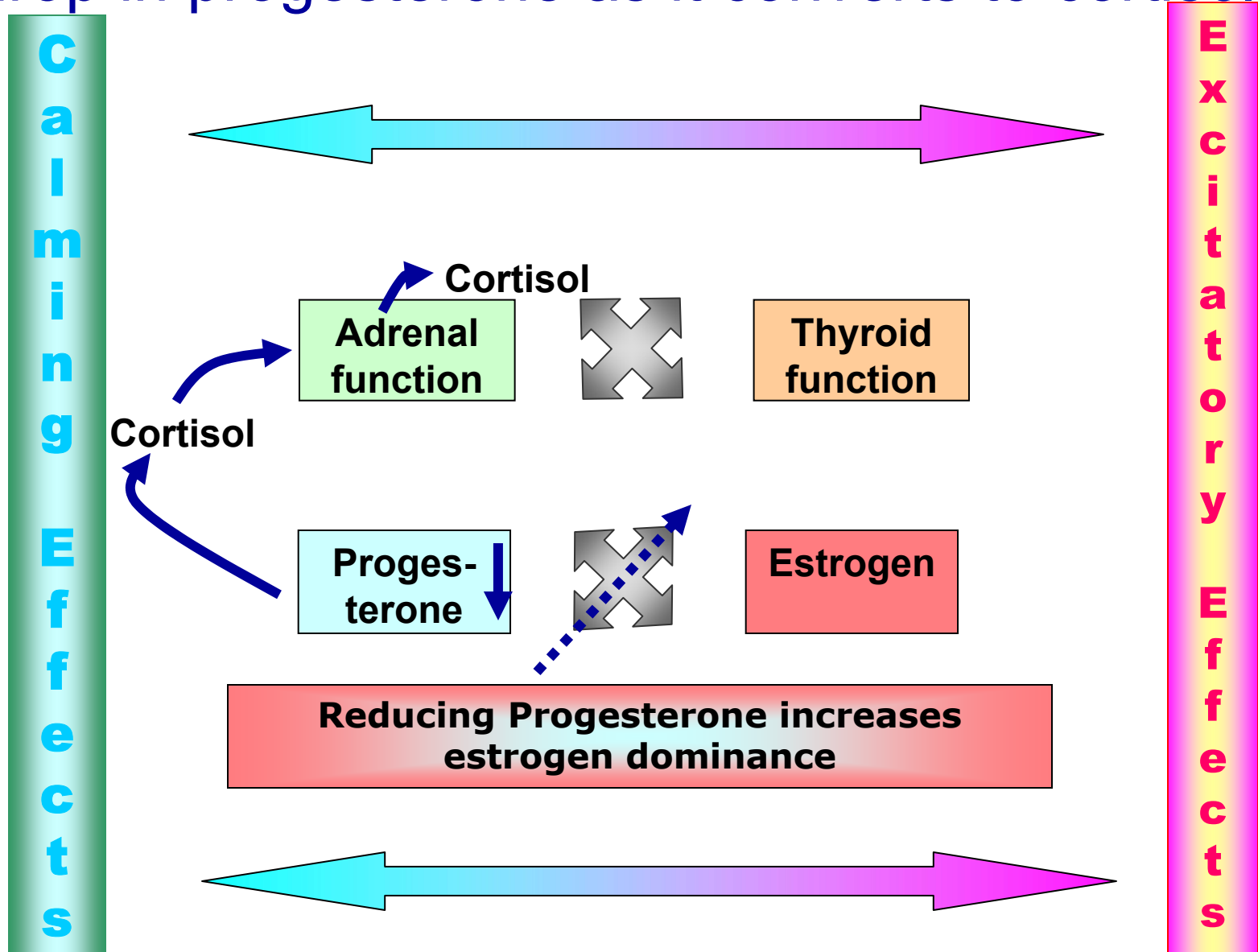
Adrenal stress depletes progesterone thus shifting the balance toward estrogen (estrogenic symptoms and effects or estrogen dominance).

When dealing with stress or if the adrenals are fatigued, the adrenals need more cortisol. Progesterone is converted to cortisol *to help the adrenals* but this can produce a *progesterone deficit*, hence Estrogen Dominance

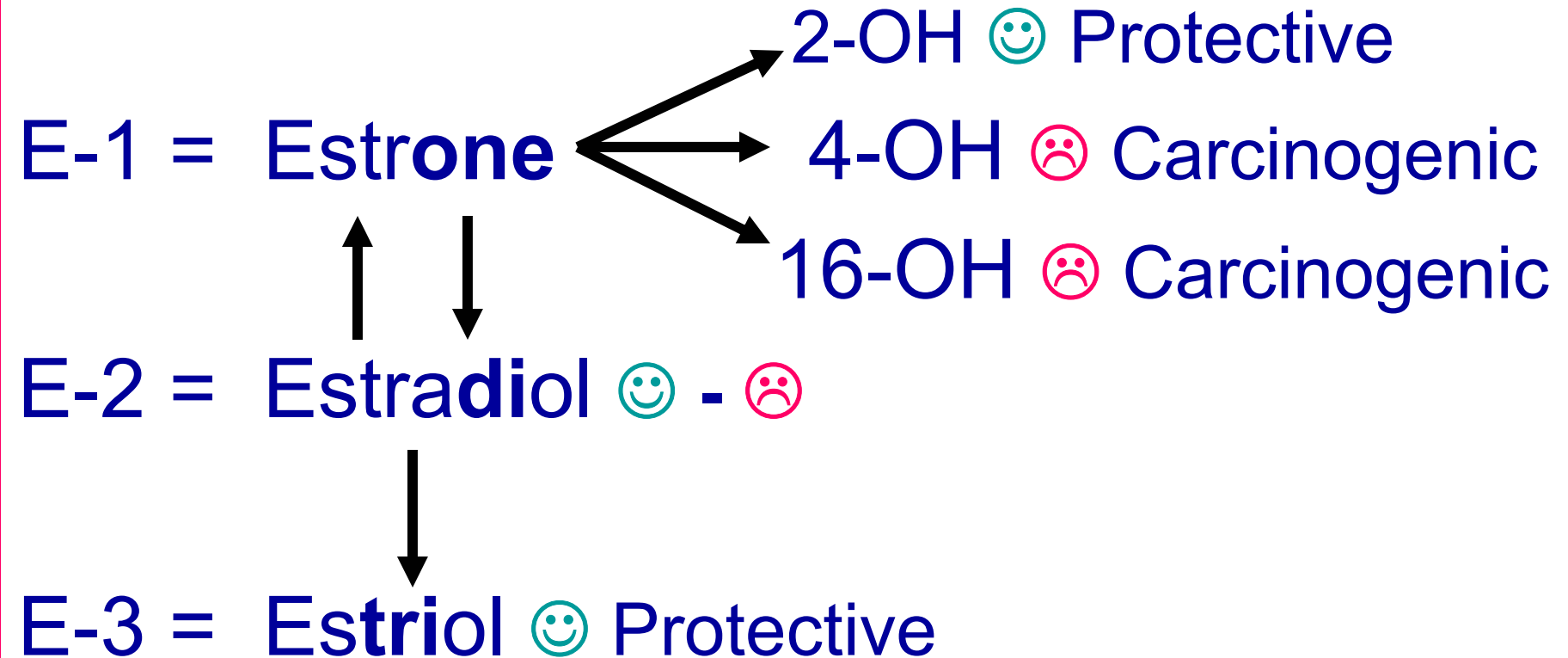
Steroid Hormone Pathways



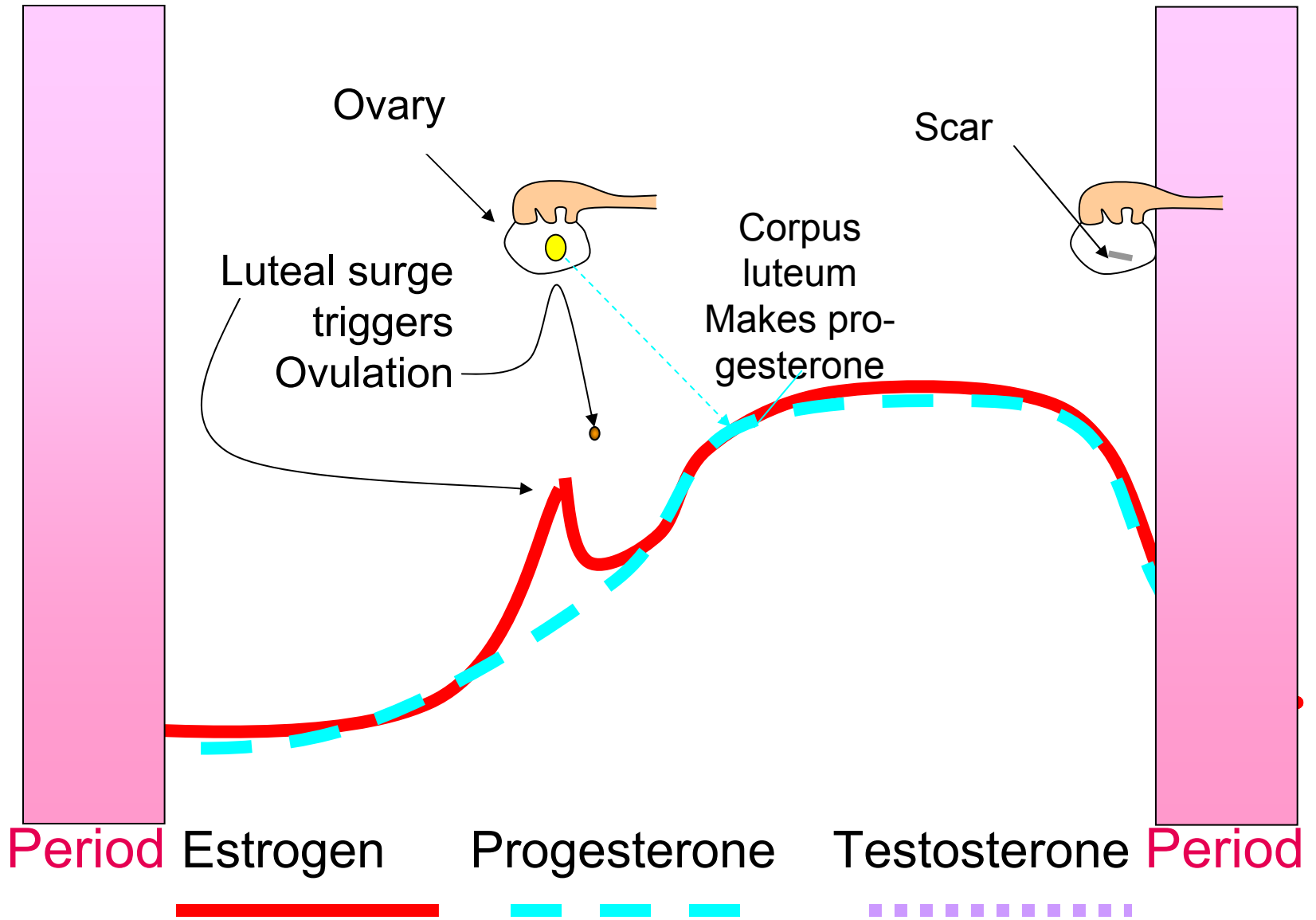
Stress causes a greater need for cortisol hence a drop in progesterone as it converts to cortisol

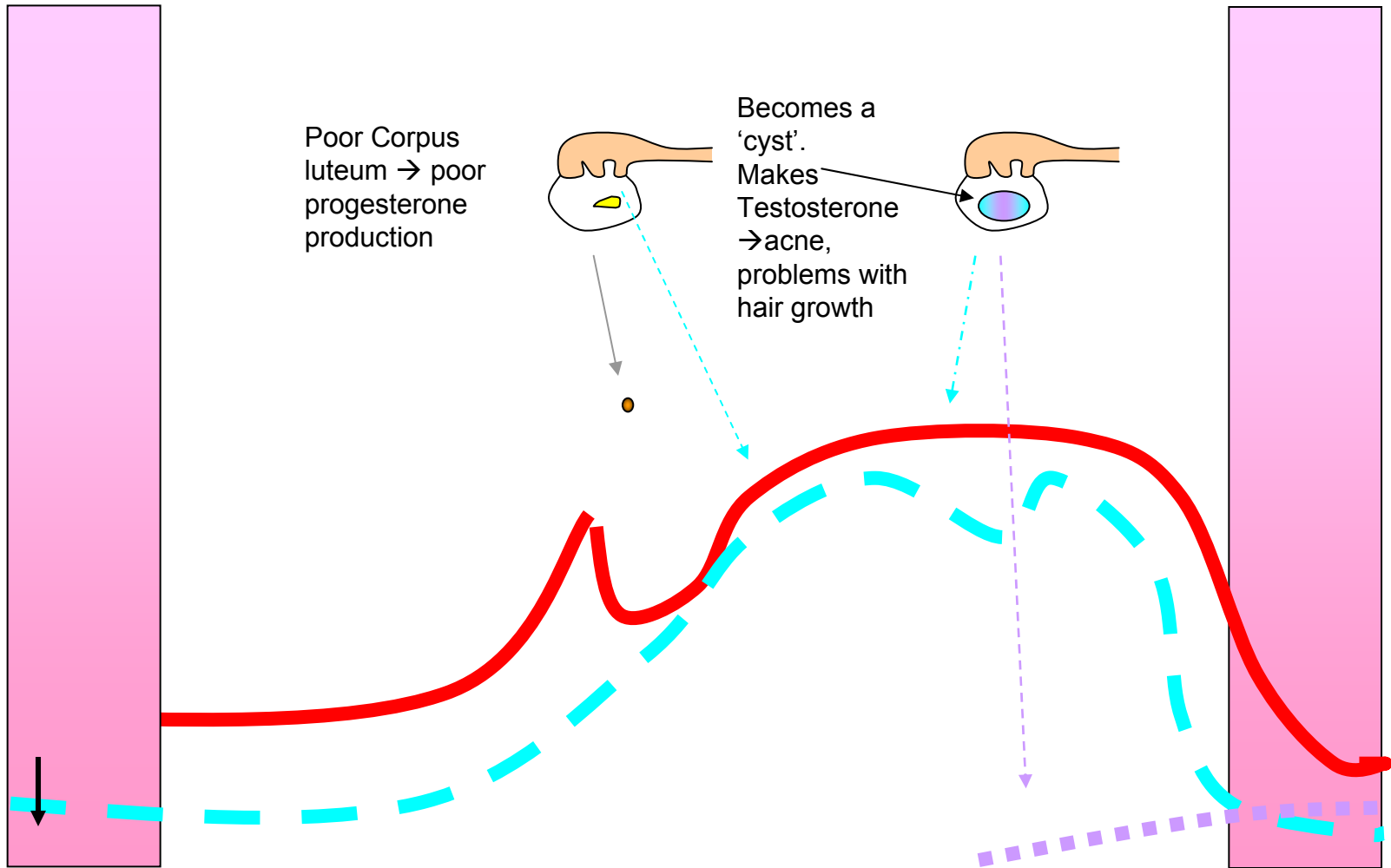


Knowing Your Estrogens



Normal Cycle





Cycle Estrogen Progesterone Testosterone **Cycle**

Fixing ED in Cycling Women

- If you have the e-FHP test (by Diagnos-Techs) graphing the entire cycle, then you can pinpoint the correction to add progesterone or even estrogen at the times needed. Having taken progesterone cream will cause a distortion of the test results falsely suggesting an excessively elevated level of progesterone.
- If no test is available, you can replace some (eg 5-20mg) progesterone at times of need (e.g., PMS)

Progesterone Replacement of Cycling Women

Obtain a *Progesterone* cream whose concentration is known and that you are able to measure out.

- During the period, 3-5mg daily (depending on personal size and need)
- Then 7-10mg daily x 8 days
- Then 15-20mg daily until the period when you return to 5 mg daily etc.
- Take more if estrogenic symptoms (eg, PMS) and less if progesterone symptoms (lethargy, sleepiness, yeast infections, constipation, weight gain)
- Apply to fatty areas for slow release (eg, abdomen) and non fatty areas for fast release (wrist).
- Progesterone helps sleep if you take at night. You can split between day dose and the night dose.

Correction of ED in cycling women

- Always support the adrenals if needed (and it usually is needed).
- If periods are irregular, you can try using **Chaste Tree (Vitex)** → First thing in AM daily. Can take months to kick in. For healthier ovulation. *Don't use if pregnant.*

Estrogen dominance repair

- Avoid substances with estrogenic effects
- DIM to reduce the carcinogenic 16-Hydroxy Estrone
Sulforaphane to reduce the carcinogenic 4-Hydroxy Estrone
- Calcium D-Glucarate to reduce estrogens via enhanced breakdown.
- Liver drainage support
- Phytoestrogen support (especially in post menopause)
- Iodine support (*if not hyperthyroid*) → may need 12.5mg tab daily (as Iodoral or Lugols solution) → start with a tiny amount daily as test dose.
- Black Cohosh, Chaste tree

Copies of the handouts
can be viewed or
downloaded from
DrRind.com

Go to the menu section on the left side of the
screen and click on Forms