Stress Survey

This survey will determine if any health problems you may be having are due to stress.

1. Check off any of the following symptoms you have experienced in the past 6 months:

- ☐ Low back pain
- ☐ Pain between shoulder blades
- ☐ Difficulty sleeping
- ☐ Tension/migraine headaches
- ☐ Tired, fatigued
- ☐ Tension across top of shoulders
- ☐ Numbness/tingling in arms or hands
- ☐ Numbness/tingling in legs or feet
- ☐ Digestive problems
- ☐ Ringing in ears
- ☐ Nervous
- ☐ Neck pan
- ☐ Allergies
- ☐ Dizziness
- ☐ Weight loss
- ☐ Weight gain

Which of the above is worst? _____

How long have you had it? _____

When it is at its worst, how does it feel? _____

2. Does this cause:

- ☐ Moodiness
- ☐ Irritability
- ☐ Interrupted sleep
- ☐ Restrictions on daily activities

3. Does this affect your work:

- ☐ Decision making
- ☐ Poor attitude
- ☐ Decreased productivity
- ☐ Exhausted at end of day
- ☐ Unable to work long hours

4. Does this affect your life:

- ☐ Lose patience with spouse or children
- ☐ Restricted household duties
- ☐ Hinders ability to exercise or participate in sports.
- ☐ Ability to participate hobbies or other desired activities

Name _____ Age _____