

STRESS SURVEY

PURPOSE: To determine if any health problems you may be having are due to stress.

Name _____ Age _____ Phone (Home) _____ (Work) _____

Address _____ City _____ State/Prov. _____ Zip/Postal _____

Occupation _____ # Hours per week currently working _____

Spouse Occupation _____ # Hours per week currently working _____

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Insomnia/Sleep Problems | <input type="checkbox"/> Irritability | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Digestive Trouble | <input type="checkbox"/> Sinus Problems/Allergies | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Pain/Tension/Numbness | <input type="checkbox"/> Constipation | <input type="checkbox"/> Asthma | <input type="checkbox"/> Weight Trouble |
| <input type="checkbox"/> Neck <input type="checkbox"/> Legs | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Shoulders <input type="checkbox"/> Arms | <input type="checkbox"/> Gas | <input type="checkbox"/> Bladder Trouble | _____ |
| <input type="checkbox"/> Low Back <input type="checkbox"/> Hands | <input type="checkbox"/> Bloating | <input type="checkbox"/> Ringing in Ears | _____ |

Which of the above bothers you the most? _____

How long have you been bothered by the condition? _____

Describe how it feels or affects you when it is at its worst. _____

2 Does this cause you to be: **3 Does this affect your work:** **4 Does this affect your life:**

- | | | |
|---|--|--|
| <input type="checkbox"/> Moody | <input type="checkbox"/> Decision Making | <input type="checkbox"/> Lose Patience with Spouse or Children |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Poor Attitude | <input type="checkbox"/> Restricted Household Duties |
| <input type="checkbox"/> Interrupt Sleep | <input type="checkbox"/> Decreased Productivity | <input type="checkbox"/> Hinders Ability to Exercise or Participate in Sports |
| <input type="checkbox"/> Restricted on Daily Activities | <input type="checkbox"/> Exhausted at End of Day | <input type="checkbox"/> Interferes with Ability to Participate in Hobbies or Other Desired Activities |
| | <input type="checkbox"/> Unable to Work Long Hours | |

FOR OFFICE USE ONLY

- There are several alternatives available to you. Please check the item most appropriate for you.
- I would like to come to the Doctor's office for a complete evaluation. This will allow me to find out if I can be helped by Chiropractic without any financial barriers.
 - I would like the Doctor to call me to discuss my health problems before making an appointment.

If possible, I would like to see the doctor on:

Monday Tuesday Wednesday Thursday Friday Saturday

The following times may or may not be available. Please select two options. Our office will call to confirm your appointment.

9 a.m. 10 a.m. 11 a.m. 12 noon 2 pm. 3 p.m. 4 p.m. 5 p.m. 6 p.m.