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_____ Zip_____

E-mail address_____ Cell Phone_____

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:

- ☐ Headaches/ Migraines
- ☐ Fatigue
- ☐ Pain/Tension/Numbness
  - ☐ Neck ☐ Legs
  - ☐ Shoulders ☐ Arms
  - ☐ Low Back ☐ Hands
- ☐ Insomnia/Sleep Problems
- ☐ Irritability
- ☐ Digestive Trouble
  - ☐ Constipations ☐ Diarrhea
  - ☐ Gas ☐ Bloating
- ☐ Sinus Problems/Allergies
- ☐ Menstrual problems
- ☐ Asthma
- ☐ Bladder Trouble
- ☐ Ringing in Ears
- ☐ Nervousness
- ☐ Dizziness
- ☐ Weight Trouble
- ☐ Other _____
  _____
  _____

Which of the above bother you the most? _____

How long have you been bothered by this condition?_____

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

2 Does this cause you to be:

- ☐ Moody
- ☐ Irritable
- ☐ Interrupt Sleep
- ☐ Restricted on Daily Actives

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
- ☐ Interferes with Ability to Participate in Hobbies or Other Desired Activities

If you could eliminate one of the above which would it be? _____

There are several alternatives available to you. Pleas check the item most appropriate for you.

☐ I would like to come to the Doctor's office for a complete evaluation. There is **NO CHARGE** for this examination. 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.

☐ I would like to come in on: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ A.M. ☐ P.M.

Are you a member of an HMO Health Care Network? ☐ Yes ☐ No Name of HMO _____