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 _____

E-mail address _____ Cell Phone _____

Occupation _____ # Hours per week currently working _____

1 Check off any of the following symptoms you have experienced in the past 30 days:

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

Which of the above bothers you the most? _____

How long have you been bothered by the condition? _____

2 Does this problem affect your ability to enjoy work?

☐ Yes ☐ No

3 Does this problem affect your ability to enjoy family and friends?

☐ Yes ☐ No

4 Does this problem affect your ability to sleep?

☐ Yes ☐ No

If you checked any of the above items, then you could be suffering from:

- **UNDETECTED NERVE DAMAGE**
- **DESTRUCTIVE EFFECTS OF STRESS**
- **CHEMICAL TOXICITY**

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

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 free in depth consultation and testing to determine the cause of my problems.
- ❑ 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.

 ITEM # 317