

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/Tension | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Pain Between Shoulder Blades | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Fatigue, Tired | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Tension Across Top of Shoulders |
| <input type="checkbox"/> Pain Anywhere in Body | <input type="checkbox"/> Wrist/Hand Pain | <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> Numbness / Tingling In Arms or Hands |
| <input type="checkbox"/> Digestive Disturbance | <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Numbness / Tingling in Legs or Feet |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Nervous | <input type="checkbox"/> Weight Trouble |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other _____ |

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:

- ☐ Moody
- ☐ Irritable
- ☐ Interrupt Sleep
- ☐ Restricted 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
- ☐ Interferes with Ability to Participate in Hobbies or Other Desired Activities

If you checked any of the above items, your organs are probably not functioning as well as they could, and your energy is probably not flowing as smoothly as it could be.

ACUPUNCTURE AND CHINESE HERBAL MEDICINE CAN HELP YOU because they gently and naturally treat the body to remove the stress and imbalance that CAUSE health problems.

WOULD YOU LIKE TO GET RID OF THE PROBLEM? ☐ YES ☐ NO

If your answer is Yes, there are several alternatives available to you. Please check the most appropriate for you:

- ☐ I would like to come to the Acupuncturist's office for an initial evaluation and consultation. There is NO CHARGE for this visit. This will allow me to find out if I can be helped by Acupuncture and Chinese Herbal Medicine without any financial barriers.
- ☐ I would like to come for further wellness classes.