

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

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, then you could be suffering from:

- | | | |
|-----------------------|------------------------------|---------------------|
| ○ EXCESSIVE
STRESS | ○ STRUCTURAL
MISALIGNMENT | ○ PINCHED
NERVES |
|-----------------------|------------------------------|---------------------|

CHIROPRACTIC CAN HELP YOU because Chiropractic Doctors gently treat the body, naturally, without drugs to remove the stress and imbalances that **CAUSE** health problems.

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 conversation with the doctor. There is **NO CHARGE** for this conversation. 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 or Health Care Network? Yes No Name of HMO _____