SPINE CORRECTION CENTER
OF THE ROCKIES

Stress Survey

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

Name:_____ **Phone:**_____

Email:_____

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

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

Which of the above bothers you the most? _____

How long have you been bothered by this condition? _____

Describe how it feels or affects you when it's 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 End of Day
- ☐ Unable to Work Long Hours

4 Does this affect your life:

- ☐ Lose Patience with Family
- ☐ Restricted Household Duties
- ☐ Hinders Ability to Exercise
- ☐ Interferes with Activity

Please rate the presentation on a scale of one to ten, one being the worst and ten being the best.

1 2 3 4 5 6 7 8 9 10
WORST BEST