

Stress Survey

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

Name: _____ Age: _____ Date _____

On a scale of 1-10 (1 being no stress and 10 being extreme stress level) please rate your daily stress levels:

Physical Stress: _____ Chemical Stress: _____ Mental/Emotional Stress: _____

Please check off any of the following symptoms you may have experienced in the past 6 months, even if they do not seem related to your current problem and check the box where you fit on the chart:

BALANCED NERVOUS SYSTEM

High Energy Few Symptoms Resistant to Infections Positive Mental Attitude
 Mentally Alert Excellent Health Active Vibrant

UNDER-AROUSSED

- Poor Attention
- Impulsive
- Easily Distracted
- Disorganised
- Depressed
- Lacking motivation
- Poor Concentration
- Spaciness
- Constipation
- Low pain threshold
- Difficulty waking
- Worry
- Irritable
- Low energy

Low

Moderate

Severe

UNSTABLE

- Migraines
- Headaches
- Seizures
- Sleepwalking
- Hot flashes
- PMS
- Food sensitivities
- Bed wetting
- Eating disorders
- Bipolar disorders
- Mood swings
- Panic attacks

Low

Moderate

Severe

OVER-AROUSSED

- Cold hands
- Cold feet
- Tight Muscles
- Teeth grinding
- Anxiety
- Heart palpitations
- Restless sleep
- Poor expression of emotions
- Poor immune system
- Racing mind
- High blood pressure
- Accelerated aging
- Irritable bowel

EXHAUSTED NERVOUS SYSTEM

Cancer Rheumatoid Arthritis Diabetes Multiple Sclerosis Depression
 Chronic Fatigue Syndrome Fibromyalgia ALS Epstein-Barr Syndrome

According to the Centers for Disease Control and Prevention, up to 90 percent of the doctor visits in the USA may be triggered by a stress-related illness.