Dr. Nancy Tarlow
www.mBodyhealth.net

Stress Survey

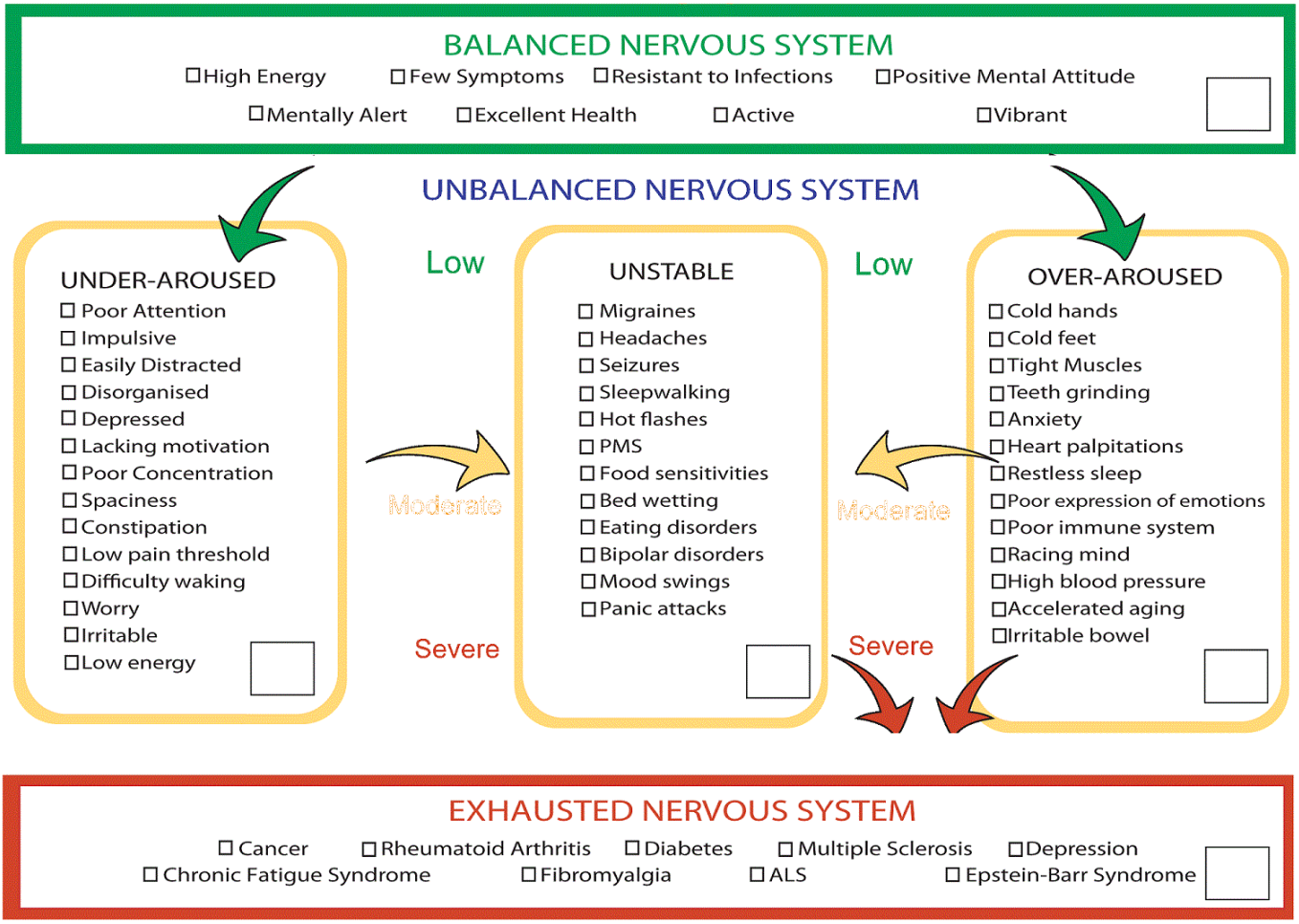
Purpose: To determine if any health problems you may be having are due to stress.

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:



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.