Pt. # ___________________

Perceived Stress & Quality of Life Survey

Name: ____ Date: ______________________

To assess your overall **response** to care and measure the improvements in your state of Health and Wellness, it is important for you to **Rate** the following on a *FREQUENCY* scale of 0-5:

0 – Never **1 – Very Rarely** (1-2 x yr.) **2 – Occasionally** (1-2 x mth) **3 – Regularly** (1 x wk) **4 – Very Frequently** (3 x wk) **5 – Constantly** (daily)

I. Physical / Chemical / Organ System Health

1. presence of physical pain (neck, back, arms, legs etc…) _____
2. feeling of tension or stiffness in spine / joints / muscles _____
3. feeling of fatigue or low energy _____
4. incidence of colds / flu / sinus congestion / allergies / infections _____
5. incidence of digestive problems / reflux / heartburn / constipation etc… _____
6. incidence of respiratory problem / asthma / bronchitis etc… _____
7. incidence of headaches (any type) / lightheadedness / dizziness _____
8. incidence of eczema / skin rash / brittle nails / loss of hair _____
9. incidence of numbness / tingling in extremities _____
10. incidence of rapid / irregular / skipping heart beat / rhythm _____
11. incidence of bladder incontinence / difficulty or frequent urination / infection _____
12. incidence of menstrual irregularity / discomfort / heavy bleeding _____
13. incidence of sexual dysfunction / arousal difficulty _____
14. incidence of craving sweets, sugars or salty foods _____
15. incidence of accidents / near accidents / slips / falls / clumsiness _____

II. Mental / Emotional Health

1. feelings of significant anxiety / restlessness / worry / guilt _____
2. feelings of depression / lack of interest in life / isolation _____
3. incidence of moodiness/ angry outbursts / over reacting to situations _____
4. difficulty in concentrating / easily distracted / unfocused or foggy thinking _____
5. tendency to procrastinate / leaving things unfinished _____
6. difficulty in falling or staying asleep / mind won't quiet down _____
7. tendency to want to over sleep / feelings of ambivalence _____
8. feelings of being rushed / overwhelmed _____
9. incidence of traumatic / frightful / or disturbing dreams _____
10. feelings of sadness / lack of joy / bouts of crying _____

III. Personal / Work Lifestyle

1. incidence of difficulty / upset in family life _____
2. incidence of difficulty / upset in work life _____
3. incidence of difficulty / upset in romantic life _____
4. feelings of dissatisfaction in social life _____
5. incidence of worry in financial life _____
6. feelings of dissatisfaction in pursuit of personal achievement / goals and dreams _____
7. poor eating / dietary habits / irregular schedule _____
8. sedentary lifestyle / lack of regular exercise _____
9. poor time management / lack of planning _____
10. tendency for little down time / relaxation / no recreation time / hobbies _____

Overall Self Rating - please **Rate** the following overall areas on the following **1 –10** scale:

1 ---------2---------3---------4---------5---------6---------7---------8---------9---------10
terrible poor satisfactory good great

Physical Health _______ Mental /Emotional Health _______ Personal / Work Lifestyle _______

Your Perceived Quality of Life Rating (total above three scores): **_______/ 30**

(Quality of Life is directly related to improvements in Health and Lifestyle Choices)