

Name _____ Date _____

||||| Your Current Health Status |||||

Physical State: Rate the following questions on a frequency scale of 1 to 5.

1 = never, 2 = rarely, 3 = occasional, 4 = regularly, 5 = constantly.

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|---|---|---|---|---|---|
| 1. Presence of physical pain (neck/back ache, sore arms/legs, etc.). | 1 | 2 | 3 | 4 | 5 |
| 2. Feeling of tension, stiffness, or lack of flexibility in your spine. | 1 | 2 | 3 | 4 | 5 |
| 3. Incidence of fatigue or low energy. | 1 | 2 | 3 | 4 | 5 |
| 4. Incidence of colds and flu. | 1 | 2 | 3 | 4 | 5 |
| 5. Incidence of headaches (any kind). | 1 | 2 | 3 | 4 | 5 |
| 6. Incidence of nausea or constipation. | 1 | 2 | 3 | 4 | 5 |
| 7. Incidence of menstrual discomfort. | 1 | 2 | 3 | 4 | 5 |
| 8. Incidence of allergies or eczema or skin rash. | 1 | 2 | 3 | 4 | 5 |
| 9. Incidence of dizziness or lightheadedness. | 1 | 2 | 3 | 4 | 5 |
| 10. Incidence of accidents or near accidents or falling or tripping. | 1 | 2 | 3 | 4 | 5 |

Mental/Emotional State: Rate the following questions on a frequency scale of 1 to 5.

1 = never, 2 = rarely, 3 = occasional, 4 = regularly, 5 = constantly.

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| 1. If pain is present, how stressed are you about it? | 1 | 2 | 3 | 4 | 5 |
| 2. Presence of negative or critical feelings about yourself. | 1 | 2 | 3 | 4 | 5 |
| 3. Experience of moodiness or temper or angry outbursts. | 1 | 2 | 3 | 4 | 5 |
| 4. Experience of depression or lack of interest. | 1 | 2 | 3 | 4 | 5 |
| 5. Being overly worried about small things. | 1 | 2 | 3 | 4 | 5 |
| 6. Difficulty thinking or concentrating or indecisiveness. | 1 | 2 | 3 | 4 | 5 |
| 7. Experience of vague fears or anxiety. | 1 | 2 | 3 | 4 | 5 |
| 8. Being fidgety or restless; difficulty sitting still. | 1 | 2 | 3 | 4 | 5 |
| 9. Difficulty falling or staying asleep. | 1 | 2 | 3 | 4 | 5 |
| 10. Experience of recurring thoughts or dreams. | 1 | 2 | 3 | 4 | 5 |

Stress Evaluation: Evaluate your stress relative to the following with,

1 = none, 2 = slight, 3 = moderate, 4 = pronounced, 5 = extensive.

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| 1. Family | 1 | 2 | 3 | 4 | 5 |
| 2. Significant Relationship | 1 | 2 | 3 | 4 | 5 |
| 3. Health | 1 | 2 | 3 | 4 | 5 |
| 4. Work | 1 | 2 | 3 | 4 | 5 |
| 5. School | 1 | 2 | 3 | 4 | 5 |
| 6. General well-being | 1 | 2 | 3 | 4 | 5 |
| 7. Emotional well-being | 1 | 2 | 3 | 4 | 5 |
| 8. Coping with daily problems | 1 | 2 | 3 | 4 | 5 |

Life Enjoyment: Rate the following questions on a degree scale of 1 – 5 with,

1 = extensive, 2 = considerable, 3 = moderate, 4 = slight, 5 = not at all.

1. Experience of relaxation or ease or wellbeing.	1	2	3	4	5
2. Presence of positive feelings about yourself.	1	2	3	4	5
3. Interest in maintaining a healthy lifestyle (e.g., diet, fitness, etc.).	1	2	3	4	5
4. Feeling of being open and aware/connected when relating to others.	1	2	3	4	5
5. Level of confidence in your ability to deal with adversity.	1	2	3	4	5
6. Level of compassion for, and acceptance of, others.	1	2	3	4	5
7. Satisfaction with the level of recreation in your life.	1	2	3	4	5
8. Incidence of feelings of joy and or happiness.	1	2	3	4	5
9. Time devoted to things you enjoy.	1	2	3	4	5

Overall Quality of Life: Evaluate your feelings relative to the quality of your life with,

1 = delighted, 2 = pleased, 3 = mostly satisfied, 4 = mixed, 5 = mostly dissatisfied, 6 = unhappy, 7 = terrible.

1. Your personal life.	1	2	3	4	5	6	7
2. Your job.	1	2	3	4	5	6	7
3. Your co-workers.	1	2	3	4	5	6	7
4. The actual work you do.	1	2	3	4	5	6	7
5. Your handling of problems in your life.	1	2	3	4	5	6	7
6. What you are actually accomplishing in your life.	1	2	3	4	5	6	7
7. Your self.	1	2	3	4	5	6	7
8. The extent to which you adjust to changes in your life.	1	2	3	4	5	6	7
9. Your life as a whole.	1	2	3	4	5	6	7

Any other Comments?
