

STRESS

Dr. Smith

SURVEY

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

Name Age Ph. (Home)..... (Cell).....
 Address City..... State/Prov. Zip/postal.....
 Occupation..... # Hours per week currently working.....
 Date:

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

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Headaches/ Migraines | <input type="checkbox"/> Insomnia/Sleep Problems | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Weight Trouble |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Irritability | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other..... |
| <input type="checkbox"/> Pain/Tension/Numbness | <input type="checkbox"/> Digestive Trouble | <input type="checkbox"/> Bladder Trouble | |
| <input type="checkbox"/> Neck <input type="checkbox"/> Legs | <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Ringing in Ears | |
| <input type="checkbox"/> Shoulders <input type="checkbox"/> Arms | <input type="checkbox"/> Gas <input type="checkbox"/> Bloating | <input type="checkbox"/> Nervousness | |
| <input type="checkbox"/> Low Back <input type="checkbox"/> Hands | <input type="checkbox"/> Sinus Problems/ Allergies | <input type="checkbox"/> Dizziness | |

Which of the above bothers you the most ?
 How long have you been bothered by the condition ?
 Describe how it feels or affects you when it is at its worst.....

2 Does this cause you to be: 3 Does this affect your work: 4 Does this affect your life:

- | | | |
|---|--|--|
| <input type="checkbox"/> Moody | <input type="checkbox"/> Decision Making | <input type="checkbox"/> Lose Patience with Spouse or Children |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Poor Attitude | <input type="checkbox"/> Restricted Household Duties |
| <input type="checkbox"/> Interrupt Sleep | <input type="checkbox"/> Decreased Productivity | <input type="checkbox"/> Hinders Ability to Exercise or Participate in Sports |
| <input type="checkbox"/> Restricted on Daily Activities | <input type="checkbox"/> Exhausted at End of Day | <input type="checkbox"/> Interferes with Ability to Participate in Hobbies or Other Desired Activities |
| | <input type="checkbox"/> Unable to Work Long Hours | |

If you Checked any of the above items, then you could be suffering from:

- **EXCESSIVE STRESS**
- **STRUCTURAL MISALIGNMENT**
- **PINCHED NERVES**

CHIROPRACTIC CAN HELP YOU because Chiropractic Doctors gently treat the body, naturally, without drugs to remove the stress and imbalances that CAUSE health problems.

If you could eliminate one of the above which would it be ?.....

If your answer is Yes. these are several alternatives available to you. Please check the item most appropriate for you.

- I would like to come to the Doctor's office for a complete evaluation. This will allow me to find out if I can be helped by Chiropractic without any financial barriers.
- I would like the Doctor to call me to discuss my health problems before making an appointment.