STRESS SURVEY

This survey will help determine the IMPACT OF STRESS on your HEALTH.

Name_____ Sex [ ] Male [ ] Female Age_____

Home Phone_____ Occupation_____

Address_____ City_____ St_____ Zip_____

Have you ever been to a Chiropractor before?_____ Date of last visit_____

How long has it been since you've felt really well?_____

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

[ ] Low Back Pain
[ ] Hip Pain
[ ] Knee Pain
[ ] Ankle/Feet Pain
[ ] Neck Pain
[ ] Elbow Pain
[ ] Wrist/Hand Pain
[ ] Face/Sinus Pain
[ ] Ringing in Ears
[ ] Headaches
[ ] Migraines
[ ] Pain Between Shoulder Blades
[ ] Tension Across Top of Shoulders
[ ] Shoulder Pain
[ ] Numbness/Tingles in Leg/Feet
[ ] Numbness/Tingles in Hands/Arms
[ ] Digestive Problems
[ ] Allergies
[ ] Dizziness
[ ] Fatigue
[ ] Nausea
[ ] Anxiety/Nervousness
[ ] Recurrent Colds/Flu
[ ] Menstrual Bloating/Cramping

Have you ever been involved in? [ ] Auto Accident [ ] Work Injury [ ] Other Accident

Which of the above concerns you the most?_____

When was the first time you remember having it?_____

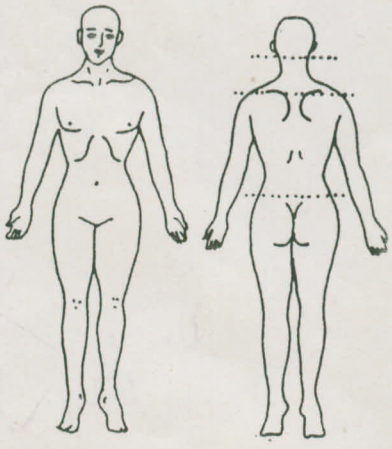
Does it cause you to be impatient, moody, or irritable? [ ] Yes [ ] No

Does it affect your family life? [ ] Yes [ ] No

Does it affect you at work? [ ] Yes [ ] No

Does it interfere with activites that you enjoy? [ ] Yes [ ] No

When it is at the worst, how bad does it make you feel?_____
(on a scale of 0 to 10, 0=no pain, 10=pain is intolerable)



Have you taken any medication for it? [ ] Yes [ ] No

Have you had any surgery for it? [ ] Yes [ ] No

Has it been getting worse? [ ] Yes [ ] No

If your problem could be thoroughly corrected, would you want to? [ ] Yes [ ] No

DR.'s Notes:_____

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You can schedule a complete examination and consultation free of charge with Dr. Jeff.
Ask for Details