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STRESS TEST

Patient: ____ Date: __________________________________

I. Physical Stress: **Explain**

When in your life did you experience any of these stresses listed below: C (child) T (teenager) A (Adult) N (Never)

Slips / falls C T A N ____

Sports Injuries C T A N ____

Poor Posture C T A N ____

Extensive Computer Work C T A N ____

Carrying Heavy Objects C T A N ____

Repetitive Lifting/Bending C T A N ____

Continues Sitting/Standing C T A N ____

Bone Fracture/ Surgery C T A N ____

Driving For Many Hours C T A N ____

Car Accidents (how many?) C T A N ____

Physical Abuse C T A N ____

Work Injuries (how many?) C T A N ____

Sleeping Position/ Stomach C T A N ____

II. Chemical Stress: **Explain**

Smoker – Amount ? C T A N ____

Second Hand Smoke C T A N ____

Poor Diet C T A N ____

Caffeine – Amount ? C T A N ____

Excessive sugar C T A N ____

Artificial Sweeteners C T A N ____

Prescription Drugs C T A N ____

Over the Counter Drugs C T A N ____

(Tylenol, Advil, etc)

Environmental Pollution (air, water, etc) C T A N ____

III. Emotional Stress: **Explain**

Relationships C T A N ____

Career C T A N ____

Children C T A N ____

Money C T A N ____

Fast-Paced Life C T A N ____

Internalized Feelings C T A N ____

Perfectionist C T A N ____

Procrastinator C T A N ____

Sickness or Loss of a Loved One C T A N ____

Quick Temper C T A N ____

Verbal Abuse C T A N ____

IV. Which do you feel is your primary stress? O Physical O Chemical or O Emotional ?

Explain:____

____

____

MEDICAL DOCTOR INFORMATION: Name: _________________________

Address: _________________________

Phone # _________________________

Is this your Primary practitioner? O Yes O No