Stress Questionnaire

Name:_____ Age:_____

Occupation _____ Position: _____

Do you actually work: □No □Yes

Is your work stressful? □No □Moderate □Very

Marital Status: □ Single □Married □Divorced □Widowed

Children? □Yes, How Many? _____ □ No

Do any other family members with stress problems?

□Yes, How Long?_____ □No

At What age did you start to feel overwhelming with stress?

_____

Why did you start experiencing stress?

□Pressure □Economy □Relationships □ Lack of Control

□Rebel against authority □Fears □ Peoples attitude □ Insecurity

Other reasons:_____

What negative impact do you get from stress?

□It makes me out of concentration □It tens me □ Gives me un-confidence

Other reasons:_____

Which behaviors often accompany your stress?

□while driving □while walking □after a meal □with coffee/tea

□at work □In bed □ Mornings Other behaviors:_____

Do you have any fears about consequences?_____

Who is important to you and why?_____

Do you have any worrying symptoms related to stress? □Yes □No

Do you have any health problems?

□Heart problems □High Blood Pressure □Diabetes □Allergies
□Ulcers □Cancer □Skin Problems □Bad digestion □Insomnia

How long do you want to live?_____

What kinds of things will you be able to do as a stress free that you could not do before?

Do you really wish to commit yourself to perceive life different?

☐Yes ☐No

What is holding you back?

_____

_____

Special Considerations:_____

_____

Date: _____

Notes