Better Body Solutions

Smart Alternatives for Optimal Health

Stress Survey

Date: _____ Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

Occupation: _____ Number of Hours Worked Weekly: _____

1 Check off any of the following symptoms you have experienced in the past 30 days:

☐	Headaches/Migraines	☐	Insomnia	☐	Sinus Problems/Allergies	☐	Ringing in Ears
☐	Fatigue	☐	Irritability	☐	Menstrual Problems	☐	Nervousness
☐	Digestive Trouble	☐	Dizziness	☐	Hormone Problems	☐	Constipation
☐	Asthma	☐	Diarrhea	☐	Weight Trouble	☐	Stress/Anxiety
☐	Bladder Trouble	☐	Bloating	☐	Other: _____		

Pain/Tension/Numbness:

☐ Neck ☐ Legs ☐ Shoulders ☐ Arms ☐ Low Back ☐ Hands

Which of the above bothers you the most? _____

How long have you been bothered by this condition? _____

2 Does this problem affect your ability to enjoy work?

☐ Yes ☐ No

3 Does this problem affect your ability to enjoy family and friends?

☐ Yes ☐ No

4 Does this problem affect your ability to sleep?

☐ Yes ☐ No

If you checked any of the above items you could be suffering from:

- **UNDETECTED NERVE DAMAGE**
- **DESTRUCTIVE EFFECTS OF STRESS**
- **CHEMICAL TOXICITY**

Do any of the following apply to you:

Heart Condition Yes No Diabetes Yes No Herniated Disc Yes No Pace Maker Yes No

Thrombosis/Blood Clot Yes No Pregnant Yes No Allergies to: _____

Which of the following services are you interested in: Massage Therapy Chiropractic

Health Insurance Company: _____

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