Stress Assessment

Name ______________________________ **Age** ________ **Sex** ________ **Date**__________

Stress is a normal part of life. Every day, we're faced with stimuli, called stressors, which can elicit the body's "fight or flight" response, setting off a cascade of physiological reactions and resulting in emotions ranging from mild to intense. But while occasional stress is natural and even healthy, chronic or acute stress can be harmful.

Please take a few moments to discover your body's response to situations you perceive as stressful. By honestly assessing how you feel, your healthcare provider can create a natural stress relief program for your individual needs.

Directions:

Please read each statement and circle the number 0, 1, 2, or 3 that best describes your feelings or reactions throughout the course of the day. Determine the subtotal score for each section, then determine the total scores for sections A-C and C-E. Some questions may appear redundant between sections. There's a reason for each question. Don't spend much time on any one question.

0 = Never true   1= Seldom true   2= Sometimes true   3= Often true

When under stress for two weeks or longer, I…

Section A:

1. Get wound up when I get tired and have trouble calming down 0 1 2 3
2. Feel driven, appear energetic but feel "burned out" and exhausted 0 1 2 3
3. Feel restless, agitated, anxious, and uneasy 0 1 2 3
4. Feel easily overwhelmed by emotion 0 1 2 3
5. Feel emotional — cry easily or laugh inappropriately 0 1 2 3
6. Experience heart palpitations or a pounding in my chest 0 1 2 3
7. Am short of breath 0 1 2 3
8. Am constipated 0 1 2 3
9. Feel warm, over-heated, and dry all over 0 1 2 3
10. Get mouth sores or sore tongue 0 1 2 3
11. Get hot flashes 0 1 2 3
12. Sleep less than seven hours a night 0 1 2 3
13. Have trouble falling asleep and staying asleep 0 1 2 3
14. Worry about high blood pressure, cholesterol, and triglycerides 0 1 2 3
15. Forget to eat and feel little hunger 0 1 2 3

Total points: ________

Section B:

1. Find myself worrying about things big and small 0 1 2 3
2. Feel like I can't stop worrying, even though I want to 0 1 2 3
3. Feel impulsive, pent up, and ready to explode 0 1 2 3
4. Get muscle spasms 0 1 2 3
5. Feel aggressive, unyielding, or inflexible when pressed for time 0 1 2 3
6. See, hear, and smell things that others do not 0 1 2 3
7. Stay awake replaying the events of the day or planning for tomorrow 0 1 2 3
8. Have upsetting thoughts or images enter my mind again and again 0 1 2 3
9. Have a hard time stopping myself from doing things again and again, like checking on things or rearranging objects over and over 0 1 2 3
10. Worry a lot about terrible things that could happen if I'm not careful 0 1 2 3

Total points: ________

Section C:

1. Have muscle and joint pains 0 1 2 3
2. Have muscle weakness 0 1 2 3
3. Crave salt or salty things 0 1 2 3
4. Have multiple points on my body that when touched are tender or painful 0 1 2 3
5. Have dark circles under my eyes 0 1 2 3
6. Feel a sudden sense of anxiety when I get hungry 0 1 2 3
7. Use medications to manage pain 0 1 2 3
8. Get dizzy when rising or standing up from a kneeling or sitting position 0 1 2 3
9. Have diarrhea or bouts of nausea with or without vomiting for no apparent reason 0 1 2 3
10. Have headaches 0 1 2 3

Total points: ________

Section D:

1. Have trouble organizing my thoughts 0 1 2 3
2. Get easily distracted and lose focus 0 1 2 3
3. Have difficulty making decisions and mistrust my judgment 0 1 2 3
4. Feel depressed and apathetic 0 1 2 3
5. Lack the motivation and energy to stay on task and pay attention 0 1 2 3
6. Am forgetful 0 1 2 3
7. Feel unsettled, restless, and anxious 0 1 2 3
8. Wake up tired and unrefreshed 0 1 2 3
9. Experience heartburn and indigestion 0 1 2 3
10. Catch colds or infections easily 0 1 2 3

Total points: ___________

Section E:

1. Feel tired for no apparent reason 0 1 2 3
2. Experience lingering mild fatigue after exertion or physical activity 0 1 2 3
3. Find it difficult to concentrate and complete tasks 0 1 2 3
4. Feel depressed and apathetic 0 1 2 3
5. Feel cold or chilled – hands, feet, or all over – for no apparent reason 0 1 2 3
6. Have little or no interest in sex 0 1 2 3
7. Sweat spontaneously during the day 0 1 2 3
8. Feel puffy and retain fluids 0 1 2 3
9. Sleep more than nine hours a night 0 1 2 3
10. Have poor muscle tone 0 1 2 3
11. Have trouble losing weight 0 1 2 3
12. Wake up tired even though I seem to get plenty of sleep 0 1 2 3
13. Have no energy and feel physically weak 0 1 2 3
14. Am susceptible to colds and the flu 0 1 2 3
15. Feel dragged down by multiple symptoms, such as poor digestion and body aches 0 1 2 3

Total points: ___________

Add points from sections A, B & C	**Total for A, B & C:** ___________
Add points from sections C, D & E	**Total for C, D & E:** ___________

LIfestyle and Health Status:

1. Circle the level of stress you experience on the scale of 1-10, 10 being the worst:
   1 2 3 4 5 6 7 8 9 10
2. What do you consider to be the major causes of your stress (for example — spouse, family, friends, work, finances, wedding, pregnancy, legal, commute):
   ____
3. I eat breakfast _________ times a week. My typical breakfast is: ______________________________
4. I take a multiple vitamin/mineral ___________ days per week. I take a fish oil supplement _____________ days per week.
5. I participate in 30 minutes of physical activity such as walking, aerobics (e.g., running), resistance training (e.g., weights, pilates), sports (e.g. biking), or yoga:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
6. I smoke ________ cigarettes daily.
7. I drink two or more 8 ounce cups of caffeinated coffee or other caffeinated beverages like energy/diet drinks, colas, or black or green teas:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
8. I drink two or more ounces of alcoholic beverages:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
9. List your current health problems and any over-the-counter or prescription medications that you are now taking:

Current health problem(s)	Date of onset	List all current medication(s)

Functional Nutrition & Health
Health History Questionnaire

Client Information

Name ___________________ **Age** ________ **Height** __________ **Weight** ____________
Address ____
Telephone (best) _____________________ **Email** _______________________________________

Reason for visit (prioritized):
1.____
2.____
3.____

Nutritional data:
How many ounces of water/day? ________What kind? ___________________________________
What other beverages and how much? ____
Do you use artificial sweeteners?________ If so, which ones? ____________________________
How often and in what? ____
Do you eat breakfast? ________ If so, what? ____

How many servings per week? (example: raw apple = 1 fresh fruit; salad = 1 raw vegetables)
Fresh fruit __________ Raw vegetables __________ Fermented foods __________
Fast foods __________ Meat __________ Eggs __________ Dairy __________
What do you crave? ____
What foods do you dislike the most? ____
Why? ____
____

Timing:
What is the first thing you do when you get up in the morning? ____________________________
____
What time do you eat your first meal? ________________ Last meal? _______________________
Which meal is your largest of the day? ____
Describe a typical "largest meal". ____
____

Movement:

Do you exercise/move/participate in fun sweaty activity? If so, what and how often?

____

Do you look forward to it? ____

How do you feel when you are finished? ____

Sleep:

What time do you go to bed? _________________ How long do you sleep? ________________

Do you wake often? __________

If so, why and at what time(s)? ____

Do you feel rested when you wake up for the day? ____________________________________

Do you have pain when you first get up? ________ If so, where?________________________

____

Does it go away upon moving? ____

Eliminations:

Do you have daily bowel eliminations? ________ If yes, how many per day?________________

If no, please describe your elimination pattern.____

____

Please describe your stools: (Color, float or sink, small hard pieces, one long piece, liquidy pile, loose stook, etc. ____

Females:

Are you post-menopausal? ________ If yes, at what age did you enter menopause? _________

What were the characteristics of your menopausal experience? __________________________

____

Do you currently use Hormone Replacement (HRT) or Hormonally-based Contraception? _____

Are you now, or in the near future, planning to become pregnant? ________________________

Is your menstrual cycle regular? ________ Longer than 28 days? ________ Shorter? _________

Is your flow longer or shorter than 5 days? ____

Do you have cramps or clotting? ________ Would you describe the color of your menses as more red, more purple, or more brown? ____

Do you experience PMS, cyclical headaches, or cravings? ________________________________

Supplements/medications:

Do you take any supplements? ________ If so, what, how often and why? _________________

____

____

Do you take any OTC medications routinely (such as Aleve or Aspirin)? If so, what and how often? ____

Do you take prescription medications (prescribed by a licensed medical professional?) If so, what and how often? ____

Medical history:

Have you had any surgeries? If so, what and when? ______________________________________

____

Have you received any diagnoses (including allergies) from a licensed medical professional? If so, what and when? ____

____

Naturopathic history:

Have you ever been in consultation with a naturopath? If so, why? How long ago?

____

____

What was suggested? ____

Did you experience a good outcome? ____

What did you like about it? ____

What wasn't as successful for you? ____

Do you have regular adjustments with a chiropractor? ____________________________________

Do you have regular body work/massages? ____

Please check all with which you are familiar:

- € Homeopathy
- € Bach Flowers/flower remedies
- € Probiotics
- € Aromatherapy
- € Muscle response testing
- € Herbals
- € Sports nutrition
- € Enzymes

I understand that I am here to learn about lifestyle and better health practices, that I will be offered information about food supplements and herbs as a guide to general good health, and this is a personal ministry and spiritual counseling. I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purpose or treatment procedures. I am not on this visit, or any subsequent visit, an agent for federal, state or local agencies or on a mission of entrapment or investigation. The services performed here are at all times restricted to consultation on holistic wellness matters intended for the maintenance of the best possible state of natural health, and do not involve the diagnosing, treatment or prescribing of remedies for disease.

Signature ____Date _____________________

FUNCTIONAL NUTRITION & HEALTH

3 Day Food & Activity Log

	Day 1	Day 2	Day 3
Wake Up Time			
Breakfast Time:			
Snack. Time:			
Lunch. Time:			
Snack. Time:			
Dinner. Time:			
Water (cups)			
Fats & Oils			
Condiments			
Exercise. (How long)			
Time spent relaxing: Doing What?			
Time to Bed			

Please take time to fill this form out completely with as much detail as possible inclucing whether the food is cooked or raw.
List your regular diet and what you actually eat so I can help you the most with possible changes.

	Name:	Date:	

Statement of Understanding & Consent

1. I voluntarily request that Functional Nutrition & Health provide recommendations for food and diet, herbs, and various nutritional and preventive health support services on or after the date of this agreement.

2. I understand that I will be given a schedule of nutrients and foods designed to supply healthy nutrition for supporting the physiological and biochemical processes of the human body. I understand that any suggested nutritional program or dietary information is not for the diagnosis, cure or treatment of any disease.

3. I have been given an opportunity to ask questions about the suggested program and it has been fully explained to me.

4. I understand that Functional Nutrition & Health is not a medical facility and they:
   A. Do not diagnose or treat any disease.
   B. Do not recommend that I discontinue any medications without first consulting my physician. (As nutritional deficiencies are addressed, less medication may be needed)

5. I understand that payment in full is required when services are rendered. Cash, checks, venmo, are accepted.

6 . I understand that if I do not give at least 24 hour advanced notice to cancel or reschedule my appointment or if I do not show up, my card will be charged $50.

______________________ ________________________________

Date **Signature**