

Identi - “T” Stress Assessment



| | |
|--------------|--|
| Patient Name | |
| Date | |
| Age | |

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 | 1 | 2 | 3 |
|------------|-------------|----------------|------------|
| Never True | Seldom True | Sometimes True | Often True |

When under stress for 2 weeks or longer, I...

| SECTION A | |
|--|--|
| 1. Get wound up when I get tired and have trouble calming down | |
| 2. Feel driven, appear energetic but feel “burned out” and exhausted | |
| 3. Feel restless, agitated, anxious, and uneasy | |
| 4. Feel easily overwhelmed by emotion | |
| 5. Feel emotional – cry easily or laugh inappropriately | |
| 6. Experience heart palpitations or a pounding in my chest | |
| 7. Am short of breath | |

| SECTION A (Cont’d) | |
|---|--|
| 8. Am constipated | |
| 9. Feel warm, over-heated, and dry all over | |
| 10. Get mouth sores or sore tongue | |
| 11. Get hot flashes | |
| 12. Sleep less than 7 hours/night | |
| 13. Have trouble falling asleep and staying asleep | |
| 14. Worry about high-blood pressure, cholesterol, and triglycerides | |
| 15. Forget to eat and feel a little hunger | |
| → TOTAL ‘A’ POINTS | |

| SECTION B | |
|--|--|
| 1. Find myself worrying about things big and small | |
| 2. Feel like I can’t stop worrying, even though I want to | |
| 3. Feel impulsive, pent up, and ready to explode | |
| 4. Get muscle spasms | |
| 5. Feel aggressive, unyielding, or inflexible when pressed for time | |
| 6. See, hear, and smell things that other do not | |
| 7. Stay awake replaying the events of the day or planning for tomorrow | |
| 8. Have upsetting thoughts or images enter my mind again and again | |

Continue to next page...



| SECTION B (Cont'd) | |
|---|--|
| 9. Have a hard time stopping myself from doing things again and again, like checking on things or rearranging objects over and over | |
| 10. Worry a lot about terrible things that could happen if I'm not careful | |
| → TOTAL 'B' POINTS | |

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

| SECTION D | |
|---|--|
| 1. Have trouble organizing my thoughts | |
| 2. Get easily distracted and lose focus | |
| 3. Have difficulty making decisions and mistrust my judgement | |
| 4. Feel depressed and apathetic | |
| 5. Lack the motivation and energy to stay on task and pay attention | |
| 6. Am forgetful | |

| SECTION D (Cont'd) | |
|--|--|
| 7. Feel unsettled, restless, and anxious | |
| 8. Wake up tired and unrefreshed | |
| 9. Experience heartburn and indigestion | |
| 10. Catch colds and/or flus easily | |
| → TOTAL 'D' POINTS | |

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



| Now, add the total points from sections: | |
|--|--|
| TOTAL OF A, B + C | |
| 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 multivitamin/mineral _____ days per week. I take a fish oil _____ days per week.

5. I partipate 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/week
 3-4 times/week
 1-2 times/week
 Less than 1/week

6. I smoke _____ cigarettes a day.

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/week
 3-4 times/week
 1-2 times/week
 Less than 1/week

8. I drink two or more ounces of alcoholic beverages:

Daily
 5-6 times/week
 3-4 times/week
 1-2 times/week
 Less than 1/week

9. List your current health problems and any over-the-counter or prescription medications you are now taking:

| Current health problems | Date of onset | List all current medications |
|-------------------------|---------------|------------------------------|
| <hr/> | <hr/> | <hr/> |
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