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ADVANCED HEALTH SERVICES, LLC.

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WRITTEN STRESS TEST RESULTS

Based on Excerpt from FEDERAL EX-STRESS U.S. Department of Health and Human Services

NAME:_____ **DOB:**____/____/____

DATE OF THE TEST: ____/____/____ _____DATE OF THE REPORT____/____/____

TEST NAME:	**TEST DATA:**
Simple Stress and Tension Test:	___ **Often** ___**Few times per week** ___**Rarely** ___**Never**
Life Style Considerations:	___ **"no"** out of necessary **6** ___ **"yes"** out of necessary **8**
Stress Affects on the Physical Body:	___ **"yes"** with permitted **2**
Stress Affects on the Mentality:	___ **"yes"** with permitted **3**
Stress Check List	___ **"yes"** ___ **"sometimes"** ___ **"no"**

SUGGESTIONS FOR LIFE STYLE CHANGE (based on the results of the Written Stress Test):

___ Avoid working more than 5-1/2 days weekly (without learning to de-stress & re-energize)

___ Avoid working more than 10 hrs. in a work day (without learning to de-stress & re-energize on the regular bases)

___ Do not take less than half an hour for each meal

___ Stop eating quickly and not chewing enough

___ Avoid smoking

___ Sleep no less than seven hours daily

___ Listen to relaxing music daily - on the way home from work (if you are not overly tired), during work or household chores.

Purchase and use Inner Peace for Busy People music CD by Joan Borysenko, PhD

___ Practice daily relaxation or meditation

Purchase and read 3 Minute Meditator by David Harp

___ Find a creative hobby (gardening, painting, reading for pleasure) and perform it at least on weekly bases

___ Play or participate in a non-competitive sport (walking, swimming, cycling) or belong to a yoga or exercise class

___ Try to have a 20-30 min. rest period during the day and a 3-5 min. "Mind Clearing Meditation"- bring your concentration upon a clears space (on the wall, sheet of paper, etc.), allowing for all of the thoughts & feelings to slow down & stay clear for 3-5 min.

___ Take a relaxing bath 20 min. ___ times weekly before bedtime

Purchase and take a bath with sea-salt for relaxation of the muscles or *lavender* candles / bath bubbles for aromatherapy relaxation effect.

___ Spend at least half an hour outdoors in the daylight each day

___ Find someone in your life to share your difficulties with (family member, friend, priest or counselor/psychologist)

SIMPLE STRESS AND TENSION TEST

Directions: please circle the column that matches frequency of the following signs of stress

1.	Often	Few times a week	Rarely	Never	I feel tense or anxious.
2.	Often	Few times a week	Rarely	Never	I have nervous indigestion.
3.	Often	Few times a week	Rarely	Never	People at work/home arouse my anger.
4.	Often	Few times a week	Rarely	Never	I eat / drink / smoke in response to tension.
5.	Often	Few times a week	Rarely	Never	I have tension or migraine headaches, pain in the neck or shoulders, or insomnia.
6.	Often	Few times a week	Rarely	Never	I can't turn off my thoughts at night or weekends long enough to feel relaxed or refreshed the next day.
7.	Often	Few times a week	Rarely	Never	I find it difficult to concentrate on what I'm doing because of worrying about other things.
8.	Often	Few times a week	Rarely	Never	I take tranquilizers (or other drugs) to relax.
9.	Often	Few times a week	Rarely	Never	I have difficulty finding enough time to relax.
10.	Yes	No			Once I find the time, it's hard for me to relax.
11.	Yes	No			My workday is made up of too many deadlines

LIFESTYLE CONSIDERATIONS

Directions: please circle the column that matches frequency of the following signs of stress

Yes	No	Sometimes	1.	Do you work more than 5-1/2 days weekly?
Yes	No	Sometimes	2.	Do you work more than 10 hours in a work day?
Yes	No	Sometimes	3.	Do you take less than half an hour for each meal?
Yes	No	Sometimes	4.	Do you eat quickly and not chew enough?
Yes	No	Sometimes	5.	Do you smoke?
Yes	No	Sometimes	6.	Do you get less than seven hours sleep daily?

Yes	No	Sometimes	1.	Do you listen to relaxing music?
Yes	No	Sometimes	2.	Do you practice daily relaxation or meditation?
Yes	No	Sometimes	3.	Do you have a creative hobby (gardening, painting, reading for pleasure)?
Yes	No	Sometimes	4.	Do you play or participate in a non-competitive sport (walking, swimming, cycling) or belong to a yoga or exercise class?
Yes	No	Sometimes	5.	Do you try to have a siesta or a short rest period during the day?
Yes	No	Sometimes	6.	Do you have regular massage or relaxing bath?
Yes	No	Sometimes	7.	Do you spend at least half an hour outdoors in the daylight each day?
Yes	No	Sometimes	8.	Do you have someone in your life to share your difficulties with (family member, friend, priest or counselor/psychologist)?

Please list the topics that bother you: _____

_____

_____

_____

Please list your fears: _____

_____

_____

_____

_____

NAME:_____**Date: ___/___/___**

Address:_____

_____

Tel.#: h. _____w. _____pag./ cell_____

HOW STRESS AFFECTS YOU

Directions: **please circle the column that matches frequency of the following signs of stress**

Yes = more than once a week / **weekly**
Sometimes = if once or twice a month / **monthly**
No = if less than monthly
There are common responses to stress, none are good or bad, right or wrong

Is stress currently affecting you <u>physically?</u>

1.	Yes	No	Sometimes	Are you experiencing difficulty in getting to asleep?
2.	Yes	No	Sometimes	Are you waking frequently in the night?
3.	Yes	No	Sometimes	Do you wake up in the early hours, unable to return right back to sleep?
4.	Yes	No	Sometimes	Are you experiencing sexual difficulties? (impotence, lack of desire for sex, etc.)
5.	Yes	No	Sometimes	Do you have difficulty in sitting still without fidgeting?
6.	Yes	No	Sometimes	Do you have headaches?
7.	Yes	No	Sometimes	Do you bite nails?
8.	Yes	No	Sometimes	Do you feel unusually tired?
9.	Yes	No	Sometimes	Do you have frequent indigestion such as heartburn?
10.	Yes	No	Sometimes	Do you crave food other than at meal times?
11.	Yes	No	Sometimes	Do you have no appetite at mealtimes?
12.	Yes	No	Sometimes	Is your bowel function erratic - sometimes constipation, sometimes loose?
13.	Yes	No	Sometimes	Do you sweat for no obvious reason?
14.	Yes	No	Sometimes	Do you have any "tics" such as touching the face, hair, mustache, repeatedly?
15.	Yes	No	Sometimes	Do you frequently feel nauseous?
16.	Yes	No	Sometimes	Do you ever faint or have dizzy spells without obvious cause?
17.	Yes	No	Sometimes	Do you feel breathless and tight-chested when not exerting yourself?
18.	Yes	No	Sometimes	Do you cry or feel the desire to cry?
19.	Yes	No	Sometimes	Are you suffering from high blood pressure?
20.	Yes	No	Sometimes	Do you feel obliged to take a drink to "unwind"?
21.	Yes	No	Sometimes	Do you smoke to calm your nerves?

Is stress affecting you <u>mentally?</u>

1.	Yes	No	Sometimes	Do you lack interest in life?
2.	Yes	No	Sometimes	Do you feel helpless and unable to cope?
3.	Yes	No	Sometimes	Are you irritable without obvious cause?
4.	Yes	No	Sometimes	Do you feel yourself to be a failure?
5.	Yes	No	Sometimes	Do you dislike yourself?
6.	Yes	No	Sometimes	Do you find it difficult to make up your mind?
7.	Yes	No	Sometimes	Are you disinterested in other people?
8.	Yes	No	Sometimes	Is it difficult to show your true feelings?
9.	Yes	No	Sometimes	Do you feel suppressed (i.e., unexpressed) anger?
10.	Yes	No	Sometimes	Do you feel your appearance has altered for the worst?
11.	Yes	No	Sometimes	Is it difficult to relax and laugh?
12.	Yes	No	Sometimes	Do you feel yourself a victim of other people's dislike or animosity?
13.	Yes	No	Sometimes	Do you feel you are neglected, or have been let down?
14.	Yes	No	Sometimes	Do you feel you have "failed" in your role as parent, spouse, or child?
15.	Yes	No	Sometimes	Do you have a fear of what the future holds?
16.	Yes	No	Sometimes	Do you feel isolated and that there is no one to turn to?
17.	Yes	No	Sometimes	Do you feel it difficult to concentrate?
18.	Yes	No	Sometimes	Do you find it difficult to complete one job well before rushing on to the next?
19.	Yes	No	Sometimes	Do you fear enclosed or open spaces?
20.	Yes	No	Sometimes	Do you feel uncomfortable in touching or being touched?

NAME: _____Date: ___/___/___

Analysis of the General Emotional Condition:

EMOTION: **FREQUENCY:** **DEGREE: 1-mild to 10 extreme**

Nervousness **daily__ weekly__ monthly__** **1__2__3__4__5__6__7__8__9__10__** **N/A**
Reasons (if known) _____
_____

Worries **daily__ weekly__ monthly__** **1__2__3__4__5__6__7__8__9__10__** **N/A**
Reasons (if known) _____
_____

Anger **daily__ weekly__ monthly__** **1__2__3__4__5__6__7__8__9__10__** **N/A**
Reasons (if known) _____
_____

Depression **daily__ weekly__ monthly__** **1__2__3__4__5__6__7__8__9__10__** **N/A**
Reasons (if known) _____
_____

Fear **daily__ weekly__ monthly__** **1__2__3__4__5__6__7__8__9__10__** **N/A**
Reasons (if known) _____
_____

Hatred **daily__ weekly__ monthly__** **1__2__3__4__5__6__7__8__9__10__** **N/A**
Reasons (if known) _____
_____

Insecurity **daily__ weekly__ monthly__** **1__2__3__4__5__6__7__8__9__10__** **N/A**
Reasons (if known) _____
_____

Loneliness **daily__ weekly__ monthly__** **1__2__3__4__5__6__7__8__9__10__** **N/A**
Reasons (if known) _____
_____

Sadness **daily__ weekly__ monthly__** **1__2__3__4__5__6__7__8__9__10__** **N/A**
Reasons (if known) _____
_____

Low Self-confidence **daily__ weekly__ monthly__** **1__2__3__4__5__6__7__8__9__10__** **N/A**
Reasons (if known) _____
_____

Jealousy **daily__ weekly__ monthly__** **1__2__3__4__5__6__7__8__9__10__** **N/A**
Reasons (if known) _____
_____

Envy **daily__ weekly__ monthly__** **1__2__3__4__5__6__7__8__9__10__** **N/A**
Reasons (if known) _____
_____

Additional: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

NAME: _____**Date:** ___/___/___

STRESS CHECKLIST: This checklist is a special opportunity to learn about yourself, to help you recognize how you respond to stress, so that you can help yourself enjoy more of life.

Directions: **please circle the space next to those items that describe your common response to stress**
There are common responses to stress, none are good or bad, right or wrong

1.	Yes	No	Sometimes	Do you become upset over little things
2.	Yes	No	Sometimes	Do you change your mind; do you become indecisive
3.	Yes	No	Sometimes	Do you become bored; nothing excites you
4.	Yes	No	Sometimes	I can't concentrate
5.	Yes	No	Sometimes	I become cranky and irritable
6.	Yes	No	Sometimes	I judge people
7.	Yes	No	Sometimes	I feel dissatisfied
8.	Yes	No	Sometimes	I forget things
9.	Yes	No	Sometimes	I can't sleep
10.	Yes	No	Sometimes	I wake up in the middle of the night
11.	Yes	No	Sometimes	I put things off
12.	Yes	No	Sometimes	I have no energy
13.	Yes	No	Sometimes	I can't eat
14.	Yes	No	Sometimes	I eat too much
15.	Yes	No	Sometimes	I lose weight
16.	Yes	No	Sometimes	I gain weight
17.	Yes	No	Sometimes	I notice changes in my complexion and / or my skin
18.	Yes	No	Sometimes	I have difficulty breathing (shortness of breath)
19.	Yes	No	Sometimes	I smoke more
20.	Yes	No	Sometimes	I drink more (alcohol)
21.	Yes	No	Sometimes	I develop allergies
22.	Yes	No	Sometimes	I don't socialize
23.	Yes	No	Sometimes	I feel my heart racing
24.	Yes	No	Sometimes	I perspire more
25.	Yes	No	Sometimes	My face feels flushed
26.	Yes	No	Sometimes	My body aches
27.	Yes	No	Sometimes	I have frequent headaches
28.	Yes	No	Sometimes	I grind my teeth
29.	Yes	No	Sometimes	I feel tired in the afternoon
30.	Yes	No	Sometimes	I am more distrustful
31.	Yes	No	Sometimes	My confidence has eroded
32.	Yes	No	Sometimes	I lose my sense of humor
33.	Yes	No	Sometimes	I am often sick, particularly with colds and fever
34.	Yes	No	Sometimes	I have a recurring physical ailment
35.	Yes	No	Sometimes	I can't relax and do nothing
36.	Yes	No	Sometimes	I work too much
37.	Yes	No	Sometimes	I shuffle papers; I can't get organized
38.	Yes	No	Sometimes	I have no interest in sex
39.	Yes	No	Sometimes	I fund it hard to show emotion
40.	Yes	No	Sometimes	I fund it hard to be around people who are acting emotionally
41.	Yes	No	Sometimes	My behavior becomes inflexible; my body tends to stiffen
42.	Yes	No	Sometimes	I feel overwhelmed by thoughts, memories, or fantasies when I encounter a specific emotion or situation
43.	Yes	No	Sometimes	I feel numb in emotional situations
44.	Yes	No	Sometimes	I am intolerant of specific people, places, or things
45.	Yes	No	Sometimes	I am "Accident Prone"
46.	Yes	No	Sometimes	I overreact
47.	Yes	No	Sometimes	I feel like a time bomb about to explode

What pattern of your behavior have you knoticed from answering the questions?
Ex.: You react in a visible, physical, or concealed manner. _____

Do you acknowledge the need for stress management? Yes No

NAME: _____ Date: ___/___/___