STANDARD PROCESS ***STRESS ASSESS*** ™

How well do you think you are handling stress? This assessment will help you and your health care professional design a personalized program to support your stress response and well-being.

Have you experienced any significant life events or changes in the last three months (illness, injury, job change, new baby, marriage, divorce, extreme training for a sporting event, major project at work, etc.)? If so, please list: _____

Hours of sleep each night:				Hours exercised per week:				Alcoholic drinks per week:				Meals eaten out per week:			
3-4 ☐	5-6 ☐	7-8 ☐	9+ ☐	0 ☐	1-2 ☐	3-5 ☐	6+ ☐	0 ☐	1-2 ☐	3-7 ☐	8+ ☐	0 ☐	1-2 ☐	3-5 ☐	6+ ☐

Do you have any downtime or participate in quiet mindfulness activities? (Pilates, yoga, meditation, quiet walks, personal hobbies) ☐ **Yes** ☐ **No**

Please answer the following questions based on your experience within the last month.	**Not at All**	**Little Bit**	**Somewhat**	**Quite a Bit**	**Very Much**
1. How stressful would you say your life is?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. Dealing with daily stresses is negatively affecting my daily tasks.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. I have a high intake of sugar and/or processed foods.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. I feel worn down and/or burnt out.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. I need caffeine or other energy drinks in the morning or afternoon to give me energy.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. I seem to have lower than usual energy during the day.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. I experience body aches and pains.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. I have periods of low moods.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9. I feel more irritable.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10. My weight and metabolism have changed.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
11. I can't seem to focus or concentrate.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
12. I have feelings of anxiousness.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
13. I feel totally exhausted most of the day and only have a few productive hours.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
14. I find myself pushing through fatigue to get things done.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
15. I seem to be sleeping a lot but never feel quite rested. I wake up feeling tired.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
16. I have difficulty getting to sleep and/or wake up in the middle of the night.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
17. I experience strong cravings for sweet or salty foods.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
18. I feel overwhelmed with daily tasks and all that is on my plate.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
19. I have a low sex drive.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
20. I am unable to enjoy socializing with family and/or friends.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Add up your total score and mark where you fall on the stress scale below. Total: _____

Low Stress **High Stress**

20 **40** **60** **80** **100**

Stress is fairly well managed in your life. It may be important to support your body to continue its healthy response.

Your body's response to stress may be getting in the way of normal activities quite frequently, leaving you feeling depleted. Consult your health care professional for an individualized program to achieve your health goals.

You may have experienced prolonged stress, and your body's stress response can no longer adapt or successfully cope. Consult your health care professional for targeted support and strategies for improvement.

Name : _____ **Date :** _____

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