Name_____**Client #**_____**Date:**_____ ☐**Assess** ☐**CM** ☐**CCSP**
☐ **Pretest** ☐**Post Test**

SURVEY OF STRESS SYMPTOMS

Please check each symptom that you have experienced in the last month and then count the number of items that you have checked. The symptoms must be experienced to the level that you identify it as a problem. Please place the total in the box at the end of the check list.

PSYCHOLOGICAL SYMPTOMS

- ☐ anxiety
- ☐ depression
- ☐ difficulty concentrating
- ☐ forgetful
- ☐ agitation, hyper
- ☐ irrational thoughts/fears
- ☐ compulsive behavior
- ☐ confusion
- ☐ feelings of unreality
- ☐ feelings of being detached from oneself
- ☐ restless/on edge
- ☐ mood swings/ irritability
- ☐ feel alone with my situation
- ☐ intrusive thoughts
- ☐ relationship problems
- ☐ family problems
- ☐ work problems
- ☐ feel unsafe
- ☐ excessive worry/obsessing
- ☐ feelings of guilt
- ☐ tearful
- ☐ nightmares
- ☐ social isolation/withdrawal
- ☐ apathy/indifference
- ☐ feel overwhelmed

PHYSICAL SYMPTOMS

- ☐ headaches
- ☐ muscle tension
- ☐ low back pain
- ☐ upper back/neck, or shoulder pain
- ☐ clenching teeth
- ☐ abdominal stress
- ☐ nausea
- ☐ shaking or trembling
- ☐ numbness or tingling
- ☐ feeling of choking
- ☐ chills or hot flashes
- ☐ sweating
- ☐ sleep disturbance
- ☐ high blood pressure
- ☐ appetite disturbance
- ☐ bowel problems
- ☐ digestive problems
- ☐ racing thoughts
- ☐ rash/hives/shingles
- ☐ use of alcohol/cigarettes or other drugs to deal with stress
- ☐ jumpy/startle easy
- ☐ can't focus/concentrate
- ☐ stress-related health problems
- ☐ fatigue
- ☐ intrusive thoughts/flashbacks

ESTIMATE YOUR STRESS LEVEL

Number of items checked	Estimated level of stress
0-7	Low (within normal range)
8-14	Moderate (experiencing some distress)
15-21	High (experiencing difficulty coping)
22+	Very high (unable to cope)

Place Stress Level Total Here: ☐ Your counselor or case manager will discuss the survey with you.