

STRESS SYMPTOM CHECKLIST

NAME: _____ DATE: _____

Instruction: check each item that describes a symptom you have experienced to any significant degree during the last month; then total the number of items checked.

Physical Symptoms

- Headaches (migraine or tension)
- Backaches
- Tight muscles
- Neck and shoulder pain
- Jaw tension
- Muscle cramps, spasms
- Nervous Stomach
- OTHER PAIN
- Nausea
- Insomnia (sleeping poorly)
- Fatigue, lack of energy
- Cold hands and/or feet
- Tightness or pressure in the head
- High blood pressure
- Diarrhea
- Skin Condition (e.g., rash)
- Allergies
- Teeth grinding
- Digestive upsets (cramps, bloating)
- Heart beats rapidly or pounds, even at rest
- Stomach pain or ulcer
- Constipation
- Hypoglycemia
- Appetite change
- Colds
- Profuse perspiration
- Overeating
- Weight change
- When nervous, use of alcohol, cigarettes or recreational drugs

Psychological Symptoms

- Anxiety
- Depression
- Confusion or “spaciness”
- Irrational fears
- Compulsive behavior
- Forgetfulness
- Feeling “overloaded or overwhelmed”
- Hyperactivity – feeling you can’t slow down
- Mood swings
- Loneliness
- Problems with relationships
- Dissatisfied /unhappy w/work
- Difficulty concentrating
- Frequent Irritability
- Restlessness
- Frequent boredom
- Frequent worrying / obsessing
- Frequent guilt
- Temper flare-ups
- Crying spells
- Nightmares
- Apathy
- Sexual problems

Evaluate your stress level as follows:

Numbers of Items Checked

0-7
8-14
15-21
22+

Total Checked: _____

Stress Level

Low
Moderate
High
Very High