MATOSHKO
Chiropractic Clinic, LLC

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STRESS SURVEY

Name: ____________________ Age: __________

Work Phone: ____________________ Home Phone: ____________________

Address: ____

City: ____________________ State: __________ ZIP: __________

Spouse Name: ____________________ Occupation: ____________________

1. Check off any of the following symptoms you have experienced in the past 6 months:

- ☐ Low Back Pain
- ☐ Muscle Stiffness
- ☐ Tension Headaches
- ☐ Tired/Fatigues
- ☐ Digestive
- ☐ Neck Pain
- ☐ Sinus Trouble
- ☐ Mid-Back Pain
- ☐ Shoulder Tension/Pain
- ☐ Numbness Arms/Hands
- ☐ Numbness Legs/Feet
- ☐ Insomnia/Sleep Problems
- ☐ Allergies
- ☐ Dizziness
- ☐ Anxiety
- ☐ Fatigue

Which of the above is the worst? ____________________

How long have you had it? ____________________

When it is at its worst, how does it feel? ____________________

2. Does this cause you to be:
   ☐ Moody ☐ Irritable ☐ Interrupt Sleep ☐ Restricts Daily Activities

3. Does this affect your work?
   ☐ Decision Making ☐ Poor Attitude ☐ Decreased Productivity ☐ Unable to Work Long Hours

4. Does this affect your life?
   ☐ Restrict Household Duties ☐ Hinders Ability to Exercise ☐ Interferes with Hobbies ☐ Exhausted at End of Day

If your answer is yes, there are several alternatives available to you. Please check the item most appropriate for you:

☐ I would like to come to the doctor's office for a complete evaluation. There is no charge for this evaluation This will allow me to find out if I can be helped by chiropractic without any financial barriers.

☐ I would like the doctor to call me to discuss my health problems before making an appointment.

If possible I would like to see the doctor on: ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

The following times may or may not be available. Our office will call to confirm:
☐ 9am ☐ 10am ☐ 11am ☐ 12pm ☐ 3pm ☐ 4pm ☐ 5pm ☐ 6pm

Do you have health insurance? ☐ Yes ☐ No Are you a member of an HMO or Healthcare Network? ☐ Yes ☐ No

Name of HMO: ____________________