

HEALTH, WELLNESS & QUALITY OF LIFE QUESTIONNAIRE

ANSWER EACH OF THE QUESTIONS BELOW BY PUTTING A CIRCLE AROUND THE NUMBER THAT **BEST** REPRESENTS YOU AT THIS TIME

NAME: _____

DATE: _____

PHYSICAL STATE:

RATE THE FOLLOWING QUESTIONS WITH RESPECT TO FREQUENCY:

| | | NEVER | RARELY | OCCASIONALLY | REGULARLY | CONSTANTLY |
|-----|--|-------|--------|--------------|-----------|------------|
| 1. | PRESENCE OF PHYSICAL PAIN (NECK/BACK ACHE, SORE ARMS/LEGS, ETC.) | 1 | 2 | 3 | 4 | 5 |
| 2. | FEELING OF TENSION OR STIFFNESS OR LACK OF FLEXIBILITY IN YOUR SPINE | 1 | 2 | 3 | 4 | 5 |
| 3. | INCIDENCE OF FATIGUE OR LOW ENERGY | 1 | 2 | 3 | 4 | 5 |
| 4. | INCIDENCE OF COLDS AND FLU | 1 | 2 | 3 | 4 | 5 |
| 5. | INCIDENCE OF HEADACHES (OF ANY KIND) | 1 | 2 | 3 | 4 | 5 |
| 6. | INCIDENCE OF NAUSEA OR CONSTIPATION | 1 | 2 | 3 | 4 | 5 |
| 7. | INCIDENCE OF MENSTRUAL DISCOMFORT | 1 | 2 | 3 | 4 | 5 |
| 8. | INCIDENCE OF ALLERGIES OR SKIN RASHES | 1 | 2 | 3 | 4 | 5 |
| 9. | INCIDENCE OF DIZZINESS OR LIGHT-HEADEDNESS | 1 | 2 | 3 | 4 | 5 |
| 10. | INCIDENCE OF ACCIDENTS OR NEAR ACCIDENTS OR FALLING OR TRIPPING | 1 | 2 | 3 | 4 | 5 |

MENTAL/EMOTIONAL STATE:

RATE THE FOLLOWING QUESTIONS WITH RESPECT TO FREQUENCY:

| | | NEVER | RARELY | OCCASIONALLY | REGULARLY | CONSTANTLY |
|-----|---|-------|--------|--------------|-----------|------------|
| 1. | IF PAIN IS PRESENT, HOW DISTRESSED ARE YOU ABOUT IT? | 1 | 2 | 3 | 4 | 5 |
| 2. | PRESENCE OF NEGATIVE OR CRITICAL FEELINGS ABOUT YOUR SELF | 1 | 2 | 3 | 4 | 5 |
| 3. | EXPERIENCE OF MOODINESS OR TEMPER OR ANGRY OUTBURSTS | 1 | 2 | 3 | 4 | 5 |
| 4. | EXPERIENCE OF DEPRESSION OR LACK OF INTEREST | 1 | 2 | 3 | 4 | 5 |
| 5. | BEING OVERLY WORRIED ABOUT SMALL THINGS | 1 | 2 | 3 | 4 | 5 |
| 6. | DIFFICULTY THINKING OR CONCENTRATING OR INDECISIVENESS | 1 | 2 | 3 | 4 | 5 |
| 7. | EXPERIENCE OF VAGUE FEARS OR ANXIETY | 1 | 2 | 3 | 4 | 5 |
| 8. | BEING FIDGETY OR RESTLESS; DIFFICULTY SITTING STILL | 1 | 2 | 3 | 4 | 5 |
| 9. | DIFFICULTY FALLING OR STAYING ASLEEP | 1 | 2 | 3 | 4 | 5 |
| 10. | EXPERIENCE OF RECURRING THOUGHTS OR DREAMS | 1 | 2 | 3 | 4 | 5 |

STRESS EVALUATION:

EVALUATE YOUR STRESS RELATIVE TO THE FOLLOWING:

| | | NONE | SLIGHT | MODERATE | PRONOUNCED | EXTENSIVE |
|-----|------------------------------|------|--------|----------|------------|-----------|
| 1. | FAMILY | 1 | 2 | 3 | 4 | 5 |
| 2. | SIGNIFICANT RELATIONSHIP | 1 | 2 | 3 | 4 | 5 |
| 3. | HEALTH | 1 | 2 | 3 | 4 | 5 |
| 4. | FINANCES | 1 | 2 | 3 | 4 | 5 |
| 5. | SEX LIFE | 1 | 2 | 3 | 4 | 5 |
| 6. | WORK | 1 | 2 | 3 | 4 | 5 |
| 7. | SCHOOL | 1 | 2 | 3 | 4 | 5 |
| 8. | GENERAL WELL BEING | 1 | 2 | 3 | 4 | 5 |
| 9. | EMOTIONAL WELL BEING | 1 | 2 | 3 | 4 | 5 |
| 10. | COPING WITH DAILY CHALLENGES | 1 | 2 | 3 | 4 | 5 |

LIFE ENJOYMENT:

RATE THE FOLLOWING AS APPLICABLE TO YOUR LIFE

| | | NOT AT ALL | SLIGHT | MODERATE | CONSIDERABLE | EXTENSIVE |
|-----|---|------------|--------|----------|--------------|-----------|
| 1. | OPENNESS TO GUIDANCE TO YOUR 'INNER VOICE/FEELINGS'. | 1 | 2 | 3 | 4 | 5 |
| 2. | EXPERIENCE OF RELAXATION OR EASE OR WELL-BEING. | 1 | 2 | 3 | 4 | 5 |
| 3. | PRESENCE OF POSITIVE FEELINGS ABOUT YOURSELF. | 1 | 2 | 3 | 4 | 5 |
| 4. | INTEREST IN MAINTAINING A HEALTHY LIFESTYLE (E.G., DIET, FITNESS, ETC). | 1 | 2 | 3 | 4 | 5 |
| 5. | FEELING OF BEING OPEN AND AWARE/CONNECTED WHEN RELATING TO OTHERS. | 1 | 2 | 3 | 4 | 5 |
| 6. | LEVEL OF CONFIDENCE IN YOUR ABILITY TO DEAL WITH ADYERSITY. | 1 | 2 | 3 | 4 | 5 |
| 7. | LEVEL OF COMPASSION FOR, AND ACCEPTANCE OF, OTHERS. | 1 | 2 | 3 | 4 | 5 |
| 8. | SATISFACTION WITH THE LEVEL OF RECREATION IN YOUR LIFE. | 1 | 2 | 3 | 4 | 5 |
| 9. | INCIDENCE OF FEELINGS OF JOY OR HAPPINESS. | 1 | 2 | 3 | 4 | 5 |
| 10. | LEVEL OF SATISFACTION WITH YOUR SEX LIFE. | 1 | 2 | 3 | 4 | 5 |
| 11. | TIME DEVOTED TO THINGS YOU ENJOY. | 1 | 2 | 3 | 4 | 5 |

OVERALL QUALITY OF LIFE:

EVALUATE YOUR FEELINGS RELATIVE TO THE QUALITY OF LIFE

| | | TERRIBLE | UNHAPPY | MOSTLY DISSATISFIED | MIXED | MOSTLY SATISFIED | PLEASED | DELIGHTED |
|-----|--|----------|---------|---------------------|-------|------------------|---------|-----------|
| 1. | YOUR PERSONAL LIFE. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. | YOUR WIFE/HUSBAND OR SIGNIFICANT OTHER. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. | YOUR ROMANTIC LIFE. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. | YOUR JOB/WORK. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. | YOUR CO-WORKERS. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. | THE ACTUAL WORK YOU DO. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. | THE HANDLING OF PROBLEMS IN YOUR LIFE. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. | WHAT YOU ARE ACTUALLY ACCOMPLISHING IN YOUR LIFE. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. | PHYSICAL APPEARANCE - THE WAY YOU LOOK TO OTHERS. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. | PHYSICAL APPEARANCE - THE WAY YOU LOOK AT YOUR SELF. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. | YOUR ABILITY TO ADJUST TO CHANGE IN YOUR LIFE. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. | YOUR LIFE AS A WHOLE. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 13. | OVERALL CONTENTMENT WITH YOUR LIFE. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 14. | THE EXTENT TO WHICH YOUR LIFE HAS BEEN AS YOU WANT IT. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

OVERALL INTERNAL AWARENESS

SKIP THIS SECTION IF THIS IS YOUR FIRST VISIT.

ANSWER THESE QUESTIONS IN COMPARISON TO HOW YOU FELT WHEN YOU FIRST CAME TO THE OFFICE:

YOU MAY CHOOSE MORE THAN ONE ANSWER AND/OR ADD SHORT DESCRIPTIONS AT BOTTOM

| | | BETTER | SAME | WORSE | MORE CREATIVE RESPONSES | AWARE OF MORE CHOICES |
|----|---|--------|------|-------|-------------------------|-----------------------|
| 1. | OVERALL MY PHYSICAL WELL-BEING IS: | 1 | 2 | 3 | 4 | 5 |
| 2. | OVERALL MY MENTAL STATE IS: | 1 | 2 | 3 | 4 | 5 |
| 3. | OVERALL MY EMOTIONAL STATE IS: | 1 | 2 | 3 | 4 | 5 |
| 4. | OVERALL MY ABILITY TO HANDLE STRESS IS: | 1 | 2 | 3 | 4 | 5 |
| 5. | OVERALL MY ENJOYMENT OF LIFE IS: | 1 | 2 | 3 | 4 | 5 |
| 6. | OVER MY QUALITY OF LIFE IS: | 1 | 2 | 3 | 4 | 5 |
| 7. | INCIDENCE OF MENSTRUAL DISCOMFORT | 1 | 2 | 3 | 4 | 5 |
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