Opus Acupuncture
Timothy O'Brien DA, M.Ac.
Doctor of Acupuncture

Stress Survey

Purpose:
To determine if any health problems you may be having are due to stress. All information will be kept in strict confidence. We will never share your information with anyone.

Fill out the information as it applies to you completely.

1. Check the box for any symptom you have experienced in the past 6 months.

	Headaches / Tension		Difficulty Sleeping		Digestive problems
	Tired / Fatigue		Irritability		Allergies
	Lower Back pain		Nervousness		Infertility
	Hand / Wrist pain		Dizziness		Numbness/Tingling Arms
	Elbow Pain		Depression		Numbness/Tingling Hands
	Neck / Shoulder Pain		Migraines		Numbness/Tingling Legs
	Knee Pain		Ankle / Foot Pain		Numbness/Tingling Feet
	Hip Pain		Shoulder Tension		Weight Problem
	Other: Please specify:				

Which of the above bothers you the most?_____

How long have you been bothered by this condition? _____

Describe how it makes you feel when it is at its' worst? _____

Using the scale from 1 - 10 (where 10 is worst pain) What is your pain level #_____

If you checked any items on the list above, your body is not functioning as well as it could be. If you would like additional information on stress or any other health topic, complete the section below and our office will contact you.

Name: _____ Telephone #: _____

EMAIL : _____ Cellular #:_____

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Located at 66 Nooseneck Hill Road (Rt. 3), W. Greenwich, RI
Telephone: 401-397-6333 Fax: 401-397-3124