Health Status Questionnaire

Physical State
Rate the following questions on a frequency scale of 1 to 5.

1. Presence of physical pain (neck/back ache, sore arms/legs, etc.)
   - never 1, rare 2, occas. 3, regular 4, constant 5
2. Feeling of tension, stiffness, or lack of flexibility in your spine.
   - never 1, rare 2, occas. 3, regular 4, constant 5
3. Incidence of fatigue or low energy.
   - never 1, rare 2, occas. 3, regular 4, constant 5
4. Incidence of colds and flu.
   - never 1, rare 2, occas. 3, regular 4, constant 5
5. Incidence of headaches (of any kind).
   - never 1, rare 2, occas. 3, regular 4, constant 5
6. Incidence of nausea or constipation.
   - never 1, rare 2, occas. 3, regular 4, constant 5
   - never 1, rare 2, occas. 3, regular 4, constant 5
8. Incidence of allergies or eczema or skin rash.
   - never 1, rare 2, occas. 3, regular 4, constant 5
9. Incidence of dizziness or lightheadedness.
   - never 1, rare 2, occas. 3, regular 4, constant 5
10. Incidence of accidents or near accidents or falling or tripping.
    - never 1, rare 2, occas. 3, regular 4, constant 5

Mental/Emotional State
Rate the following questions on a frequency scale of 1 to 5.

1. If pain is present, how stressed are you about it?
   - never 1, rare 2, occas. 3, regular 4, constant 5
2. Presence of negative or critical feelings about yourself.
   - never 1, rare 2, occas. 3, regular 4, constant 5
3. Experience of moodiness or temper or angry outbursts.
   - never 1, rare 2, occas. 3, regular 4, constant 5
4. Experience of depression or lack of interest.
   - never 1, rare 2, occas. 3, regular 4, constant 5
5. Being overly worried about small things.
   - never 1, rare 2, occas. 3, regular 4, constant 5
6. Difficulty thinking or concentrating or indecisiveness.
   - never 1, rare 2, occas. 3, regular 4, constant 5
7. Experience vague fears or anxiety.
   - never 1, rare 2, occas. 3, regular 4, constant 5
8. Being fidgety or restless; difficulty sitting still.
   - never 1, rare 2, occas. 3, regular 4, constant 5
9. Difficulty falling or staying asleep.
   - never 1, rare 2, occas. 3, regular 4, constant 5
10. Experience of recurring thoughts or dreams.
    - never 1, rare 2, occas. 3, regular 4, constant 5

Stress Evaluation
Evaluate your stress relative to the following with:

1. Family
   - none 1, low 2, medium 3, high 4, very high 5
2. Significant Relationship
   - none 1, low 2, medium 3, high 4, very high 5
3. Health
   - none 1, low 2, medium 3, high 4, very high 5
4. Finances
   - none 1, low 2, medium 3, high 4, very high 5
5. Sex Life
   - none 1, low 2, medium 3, high 4, very high 5
6. Work
   - none 1, low 2, medium 3, high 4, very high 5

Please continue on back.
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 problems ........................................... 1 2 3 4 5

Life enjoyment
Rate the following questions on a scale of 1 to 5.
1. Openness to guidance by your “inner voice/feelings.” ........ 1 2 3 4 5
2. Experience of relation 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 openness and awareness/connection when relating to others. .... 1 2 3 4 5
6. Level of confidence in your ability to deal with adversity. .......... 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 and 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 your life with
terrible unhappy dissatisfied mixed satisfied pleased delighted
1. Your personal life. ............................................... 1 2 3 4 5 6 7
2. Your significant other/spouse/partner. .......................... 1 2 3 4 5 6 7
3. Your romantic life. .............................................. 1 2 3 4 5 6 7
4. Your job. .......................................................... 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. Your handling of problems in your life. ........................ 1 2 3 4 5 6 7
8. What you are actually accomplishing. .......................... 1 2 3 4 5 6 7
9. Your physical appearance—the way you look to others. ......... 1 2 3 4 5 6 7
10. Your self. ........................................................ 1 2 3 4 5 6 7
11. The extent to which you adjust to changes 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 what you wanted. .... 1 2 3 4 5 6 7