

STRESS LESS.....FOR LIFE

Date: _____

Name: _____

Address: _____

Phone: (H) _____ (W) _____ (C) _____

E-Mail Address: _____

Do you currently experience any of the following?

Frequent headaches _____

Digestive problems _____

Low energy _____

Problems sleeping _____

Irritability _____

Foggy thinking _____

Minor aches/Pains _____

Overly tired _____

Anxiety _____

Depression _____

Home/Work imbalance _____

Anger _____

Other health issues/concerns:

List the 3 main stressors in your life:

1. _____

2. _____

3. _____

How do you currently handle your stress?

Is it effective? _____

Is there any aspect of your life that would improve if you learned to manage your stress better?

