Health, Wellness & Quality of Life Questionnaire

Answer each of the following questions by placing a circle around the number that **best** represents you at this time.

Name: _____

Date: _____

Physical State

Please rate the following with respect to frequency:	Constantly	Regularly	Occasionally	Rarely	Never
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. (Ladies) 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

Please rate the following with respect to frequency:	Constantly	Regularly	Occasionally	Rarely	Never
1. If pain is present, how distressed are you about it	1	2	3	4	5
2. Presence of negative or critical feelings about yourself	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

Please evaluate the degree of stress you associate with your:	Extensive	Pronounced	Moderate	Slight	None
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 problems	1	2	3	4	5

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Life Enjoyment

Please evaluate the following on a scale of 1 to 5:	Absent	Low	Moderate	Often	Always
1. Openness to guidance from your 'inner voice' or feelings	1	2	3	4	5
2. Sense of relaxation, ease or well-being	1	2	3	4	5
3. Positive feelings about yourself	1	2	3	4	5
4. Interest in maintaining a healthy lifestyle (eg. diet, fitness etc.)	1	2	3	4	5
5. Feeling of being open and aware or connected when relating to others	1	2	3	4	5
6. Confidence in your ability to deal with adversity	1	2	3	4	5
7. 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. Feelings of joy or happiness	1	2	3	4	5
10. 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

Please rate how you feel about your:	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
1. Personal life	1	2	3	4	5	6	7
2. Wife / husband or 'significant other'	1	2	3	4	5	6	7
3. Romantic life	1	2	3	4	5	6	7
4. Employer	1	2	3	4	5	6	7
5. 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. 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. 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 as been as you want it	1	2	3	4	5	6	7

Overall Impressions

	Poor	Good	Excellent
1. Overall my physical wellbeing is	1	2	3
2. Overall my mental and emotional state is	1	2	3
3. Overall my ability to handle stress is	1	2	3
4. Overall my enjoyment of life is	1	2	3
5. Overall my quality of life is	1	2	3

Thank you !