Stress Thermometer

Name: _____ **Gender:** _____

Contact information: _____ **Date of assessment:** _____ dd / mm / yyyy

Please select the number that best describes how much stress you have been experiencing in the past week, including today.

Stress thermometer:

◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯

0 1 2 3 4 5 6 7 8 9 10

Please indicate if any of the following has been a problem for you in the past week, including today. Be sure to select YES or NO for each.

PRACTICAL PROBLEMS

Child care:

◯ Yes ◯ No

Housing:

◯ Yes ◯ No

Insurance / financial:

◯ Yes ◯ No

Transportation:

◯ Yes ◯ No

Work / school:

◯ Yes ◯ No

Treatment decisions:

◯ Yes ◯ No

FAMILY PROBLEMS

Dealing with children:

◯ Yes ◯ No

Dealing with partner:

◯ Yes ◯ No

Ability to have children:

◯ Yes ◯ No

Family health issues:

◯ Yes ◯ No

EMOTIONAL PROBLEMS

Depression:

◯ Yes ◯ No

Fears:

◯ Yes ◯ No

Nervousness:

◯ Yes ◯ No

Sadness:

◯ Yes ◯ No

Worry:

◯ Yes ◯ No

Loss of interest in usual activities:

◯ Yes ◯ No

SPIRITUAL/RELIGIOUS PROBLEMS

Spiritual/religious concerns:

◯ Yes ◯ No

PHYSICAL PROBLEMS

Appearance:

◯ Yes ◯ No

Bathing / dressing:

◯ Yes ◯ No

Breathing:

◯ Yes ◯ No

Changes in urination:

◯ Yes ◯ No

Constipation:

◯ Yes ◯ No

Diarrhea:

◯ Yes ◯ No

Eating:

◯ Yes ◯ No

Fatigue:

◯ Yes ◯ No

Feeling swollen:

◯ Yes ◯ No

Fevers:

◯ Yes ◯ No

Getting around:

◯ Yes ◯ No

Indigestion:

◯ Yes ◯ No

Memory / concentration:

◯ Yes ◯ No

Mouth sores:

◯ Yes ◯ No

Nausea:

◯ Yes ◯ No

Nose dry / congested:

◯ Yes ◯ No

Pain:

◯ Yes ◯ No

Sexual:

◯ Yes ◯ No

Skin dry / itchy:

◯ Yes ◯ No

Sleep:

◯ Yes ◯ No

Substance use:

◯ Yes ◯ No

Tingling in hands / feet:

◯ Yes ◯ No

OTHER PROBLEMS

Specify below: