4 Key Stressors Questionnaire

Patient Name: _____ **Date:** _____

Please circle **yes** or **no** for each of the following questions. Please fill in the Other sections for any unlisted issues related to each category.

After identifying and reviewing your primary stressor(s) with your health care provider, please refer to the corresponding chapter **(Chapter 1: Blood Sugar Control, Chapter 2: Mental and Emotional Stress, Chapter 3: Overcoming Insomnia, Chapter 4: Reducing Inflammation)** in the SOS Stress Recovery Program Patient Handbook for lifestyle, dietary and nutrient therapy recommendations.

Blood Sugar Imbalance

- Do you experience symptoms of hypoglycemia such as dizziness, shakiness or brain fog between or following meals? Y N
- Do you frequently miss or delay meals? Y N
- Do you frequently crave sugar or carbohydrates? Y N
- Do you consume excessive sugar or refined carbohydrates? Y N
- Are you diabetic or pre-diabetic? Y N
- Do you regularly consume alcohol or caffeine? How much per day? _____ Y N
- Do you consume food within two hours before bedtime? Y N
- Other _____

Mental and Emotional Stress

- Do you frequently experience anxiety? Y N
- Do you suffer from depression? Y N
- Do you suffer from mood swings? Y N
- Do you have difficulty getting motivated? Y N
- Do you frequently experience feelings of agitation, anger, fear or worry? Y N
- Do you consider your job, relationships or finances stressors in your daily life? Y N
- Are you a caregiver for a parent or disabled child? Y N
- Other _____

Sleep Cycle Disturbances

- Are you experiencing problems falling asleep? Y N
- Are you experiencing difficulty staying asleep? Y N
- Are you sleeping less than 7-9 hours each night? Y N
- Do you awaken not feeling well-rested in the morning? Y N
- Do you work 2nd or 3rd shift or keep late night hours? Y N
- Do you use electronic devices within two hours before bed? Y N
- Do you eat within two hours of bedtime? Y N
- Do you frequently feel drowsy throughout the day? Y N
- Do you snore? Y N
- Other _____

Inflammatory Imbalance or Chronic Pain

- Musculoskeletal: Do you suffer from headaches, muscle, back or joint pain? Y N
- Gastrointestinal: Do you suffer from IBS, Crohn's disease or diverticulitis? Y N
- Dermatological: Do you suffer from hives, eczema or psoriasis? Y N
- Respiratory: Do you suffer from asthma, bronchitis, seasonal allergies or hay fever? Y N
- Autoimmune: Do you suffer from any autoimmune condition such as MS, lupus or rheumatoid arthritis? Y N
- Immunological: Do you suffer from food allergies, chronic infections or frequent Illness? Y N
- Other _____

SOS
STRESS RECOVERY PROGRAM

Patient Name: _____

Date: _____

Implementation Plan

Key Area(s) to be Addressed:

- ☐ Mental and Emotional Stress
- ☐ Sleep Cycle Disturbances
- ☐ Blood Sugar Imbalance
- ☐ Inflammatory Imbalance

Formulation	Dose (capsules, tablets or scoops)	Frequency Per Day

Additional Recommendations: