

# Stress & Digestion Survey

From: THE REDWOOD CLINIC  
3021 Telegraph Ave., Ste C  
Berkeley, CA 94705 510-849-1176

**PURPOSE:** To determine if any health problems you may be having are due to stress.

Name \_\_\_\_\_ Age \_\_\_\_\_ Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/Postal \_\_\_\_\_

Occupation \_\_\_\_\_ # Hours per week currently working \_\_\_\_\_

Spouse Occupation \_\_\_\_\_ # Hours per week currently working \_\_\_\_\_

Email \_\_\_\_\_

## 1 Check off any of the following symptoms you have experienced in the past 6 months:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Acid Reflux /Heartburn | <input type="checkbox"/> Stomach Pain          | <input type="checkbox"/> Hiatal Hernia     | <input type="checkbox"/> Sinus Congestion                    |
| <input type="checkbox"/> Nausea                 | <input type="checkbox"/> Cramping              | <input type="checkbox"/> Moodiness         | <input type="checkbox"/> Weight gain loss                    |
| <input type="checkbox"/> Constipation           | <input type="checkbox"/> Bad Breath            | <input type="checkbox"/> Interrupted Sleep | <input type="checkbox"/> Pain/Numbness                       |
| <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Burping               | <input type="checkbox"/> Loss of Appetite  | <input type="checkbox"/> Neck <input type="checkbox"/> Legs  |
| <input type="checkbox"/> Gas                    | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Vomiting          | <input type="checkbox"/> Shoulders                           |
| <input type="checkbox"/> Bloating               | <input type="checkbox"/> Burning Sensation     | <input type="checkbox"/> Headaches         | <input type="checkbox"/> Arms <input type="checkbox"/> Hands |
|   |  |  | <input type="checkbox"/> Low Back                            |

Which of the above bothers you the most? \_\_\_\_\_

How long have you been bothered by the condition? \_\_\_\_\_

Describe how it feels or affects you when it is at its worst. \_\_\_\_\_

## 2 Does this cause you to be:      3 Does this affect your work:      4 Does this affect your life:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Moody                          | <input type="checkbox"/> Decision Making           | <input type="checkbox"/> Lose Patience with Spouse or Children   |
| <input type="checkbox"/> Irritable                      | <input type="checkbox"/> Poor Attitude             | <input type="checkbox"/> Restricted Household Duties   |
| <input type="checkbox"/> Interrupt Sleep                | <input type="checkbox"/> Decreased Productivity    | <input type="checkbox"/> Hinders Ability to Exercise or Participate in Sports                          |
| <input type="checkbox"/> Restricted on Daily Activities | <input type="checkbox"/> Exhausted at End of Day   | <input type="checkbox"/> Interferes with Ability to Participate in Hobbies or Other Desired Activities |
|   | <input type="checkbox"/> Unable to Work Long Hours |  |

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*If you checked any of the above items, your organs are probably not functioning as well as they could, and your energy is probably not flowing as smoothly as it could be.*

**ACUPUNCTURE AND CHINESE HERBAL MEDICINE CAN HELP YOU** because they gently and naturally treat the body to remove the stress and imbalance that CAUSE health problems.

**WOULD YOU LIKE TO GET RID OF THE PROBLEM?**  YES  NO

If your answer is Yes, there are several alternatives available to you. Please check the most appropriate for you:

- I would like to come to the Acupuncturist's office for an initial evaluation and consultation. There is NO CHARGE for this visit. This will allow me to find out if I can be helped by Acupuncture and Chinese Herbal Medicine without any financial barriers.
- I would like to come for further wellness classes.

Email \_\_\_\_\_

www.theredwoodclinic.com

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