

NC State Counseling Center Stress Symptom Checklist

Check each item that describes a symptom you have experienced to any significant degree during the last month, then total the number of items checked.

| Physical Symptoms | Psychological Symptoms |
|--|---|
| <input type="checkbox"/> Headaches (migraine or tension) | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Tight muscles | <input type="checkbox"/> Confusion or "spaciness" |
| <input type="checkbox"/> Neck and shoulder pain | <input type="checkbox"/> Irrational fears |
| <input type="checkbox"/> Jaw tension | <input type="checkbox"/> Compulsive behavior |
| <input type="checkbox"/> Muscle cramps, spasms | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Nervous stomach | <input type="checkbox"/> Feeling "overloaded" or "overwhelmed" |
| <input type="checkbox"/> Other pain | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Insomnia (sleeping poorly) | <input type="checkbox"/> Problems with relationships |
| <input type="checkbox"/> Fatigue, lack of energy | <input type="checkbox"/> Dissatisfied or unhappy with work |
| <input type="checkbox"/> Cold hands and/or feet | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Tightness or pressure in the head | <input type="checkbox"/> Frequent irritability |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Frequent boredom |
| <input type="checkbox"/> Skin conditions (e.g., rash) | <input type="checkbox"/> Frequent worrying or obsessing |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent guilt |
| <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Temper flare-ups |
| <input type="checkbox"/> Digestive upsets (cramps, bloating) | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Heart beats rapidly or pounds, even at rest | <input type="checkbox"/> Hyperactivity—feeling like you can't slow down |
| <input type="checkbox"/> Stomach pain or ulcer | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Apathy |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Appetite change | |
| <input type="checkbox"/> Colds | |
| <input type="checkbox"/> Profuse perspiration | |
| <input type="checkbox"/> Overeating | |
| <input type="checkbox"/> Weight change | |
| <input type="checkbox"/> When nervous, use of alcohol, cigarettes, or recreational drugs | |

Evaluate your stress level as follows:

| <i>Number of Items Checked</i> | <i>Stress Level</i> |
|--------------------------------|---------------------|
| 0-7 | Low |
| 8-14 | Moderate |
| 15-21 | High |
| 22+ | Very High |