*Management Training S1.c*

*Session One*

***Stress Assessment Questionnaire***

Name...........................................................................................................................................

How would you describe the problem?

How long have you had the problem?

How did the problem first start?

What does your Doctor say about the problem?

Have you had any treatment in the past?

Have you tried to overcome the problem in the past?

Have you had any success in overcoming the problem?

Do you suffer from any of the following?:

Headaches Diarrhoea

Blushing Allergies

Dizziness Tiredness

Heartburn Faintness

Weak knees Nightmares

Chest pains Palpitations

Itching Rash

Blurred vision Uncontrollable eye movement

Light-headedness Unreal feelings

Missed heartbeat Muscular tension

Sleep disturbance Excessive sweating

Breathlessness Sexual difficulties

Difficulty swallowing 'Lump in the throat'

Anxiety Panic attacks

Facial tics Sensitivity to light and sound

Nausea Shaking

Frightening thoughts Hating yourself

Worrying Talking too fast

Loneliness Boredom

Disorganisation Poor concentration

Poor memory Irritability

Do you fear any of the following?:

Future events Choking

Collapsing Fainting

Panic attacks Being embarrassed

Losing control Madness

Crowded places Standing in queues

Driving Being on a bus

Being on a train Being in shops

Supermarkets Leaving the house

Talking to people Eating in front of people

People looking at you Writing in front of people

Bridges Tunnels

Being alone Going to work

Social occasions Cinemas, theatres

Waiting rooms Medical examinations

Dogs Birds

Do you suffer from unpleasant thoughts that you feel are beyond your control?

Do you feel compelled to do certain actions to control these thoughts?

Do you work outside the home?

Do you live alone or with family or friends?

Have your parents or brothers/sisters ever suffered from any psychological problems?

What are your hobbies/Social life?

Do you smoke? (and how many a day, for how many years, and in what circumstances)?

Do you drink alcohol? (and how much a week, for how many years and in what circumstances)?

Are you taking any medication?

How is your physical health?

What are your most serious symptoms? How do they affect your life at the present time?

***Optional*** : Return your completed form to your coach for review: Email: info@outcomecoaching.ie