

Health, Wellness and Quality of Life Questionnaire

Name Client Number Date

Answer each of the questions below by putting a circle around the number that best represents you at this time.

Physical state	never	rarely	occasionally	regularly	constantly
1. Presence of physical pain (neck/back ache, sore arms/legs, etc)	1	2	3	4	5
2. Feeling of tension/stiffness or lack of flexibility in your spine	1	2	3	4	5
3. Incidence of fatigue or low energy	1	2	3	4	5
4. Incidence of cold or flu	1	2	3	4	5
5. Incidence of headaches (of any kind)	1	2	3	4	5
6. Incidence of nausea or constipation	1	2	3	4	5
7. Incidence of menstrual discomfort	1	2	3	4	5
8. Incidence of allergies or skin rashes	1	2	3	4	5
9. Incidence of dizziness or light-headedness	1	2	3	4	5
10. Incidence of accidents/near accidents or falling/tripping	1	2	3	4	5

Mental/emotional state	never	rarely	occasionally	regularly	constantly
1. If pain is present, how distressed are you about it?	1	2	3	4	5
2. Presence of negative or critical feelings about yourself	1	2	3	4	5
3. Experience of moodiness, temper or angry outbursts	1	2	3	4	5
4. Experience of depression or lack of interest	1	2	3	4	5
5. Being overly worried about small things	1	2	3	4	5
6. Difficulty thinking/concentrating or indecisiveness	1	2	3	4	5
7. Experience of vague fears or anxiety	1	2	3	4	5
8. Being fidgety or restless, difficulty sitting still	1	2	3	4	5
9. Difficulty falling or staying asleep	1	2	3	4	5
10. Experience of recurring thoughts or dreams	1	2	3	4	5

Stress evaluation (evaluate your stress relative to the following)	none	slight	moderate	pronounced	extensive
1. Family	1	2	3	4	5
2. Significant relationship	1	2	3	4	5
3. Health	1	2	3	4	5
4. Finances	1	2	3	4	5
5. Sex life	1	2	3	4	5
6. Work	1	2	3	4	5
7. School	1	2	3	4	5
8. General well-being	1	2	3	4	5
9. Emotional well-being	1	2	3	4	5
10. Coping with daily problems	1	2	3	4	5

Life enjoyment (evaluate your stress relative to the following)

	not at all	slight	moderate	considerable	extensive
1. Openness to guidance to your “inner voice/feelings”	1	2	3	4	5
2. Experience of relaxation/ease or well-being	1	2	3	4	5
3. Presence of positive feelings about yourself	1	2	3	4	5
4. Interest in maintaining a healthy lifestyle (eg diet, fitness, etc)	1	2	3	4	5
5. Feeling of being open and aware/connected when relating to others	1	2	3	4	5
6. Level of confidence in your ability to deal with adversity	1	2	3	4	5
7. Level of compassion for, and acceptance of, others	1	2	3	4	5
8. Satisfaction with the level of recreation in your life	1	2	3	4	5
9. Incidence of feelings of joy or happiness	1	2	3	4	5
10. Level of satisfaction with your sex life	1	2	3	4	5
11. Time devoted to things you enjoy	1	2	3	4	5

Quality of life (evaluate your feelings relative to the following)

	terrible	unhappy	mostly unhappy	mixed	mostly pleased	pleased	delighted
1. Your personal life	1	2	3	4	5	6	7
2. Your wife/husband or significant other	1	2	3	4	5	6	7
3. Your romantic life	1	2	3	4	5	6	7
4. Your job	1	2	3	4	5	6	7
5. Your co-workers	1	2	3	4	5	6	7
6. The actual work you do	1	2	3	4	5	6	7
7. The handling of problems in your life	1	2	3	4	5	6	7
8. What you are actually accomplishing in your life	1	2	3	4	5	6	7
9. Physical appearance - the way you look to others	1	2	3	4	5	6	7
10. Your self	1	2	3	4	5	6	7
11. Your ability to adjust to change in your life	1	2	3	4	5	6	7
12. Your life as a whole	1	2	3	4	5	6	7
13. Overall contentment with your life	1	2	3	4	5	6	7
14. Extent to which your life has been as you want it	1	2	3	4	5	6	7

Overall impressions

	better	same	worse
1. Overall my physical well-being is	1	2	3
2. Overall my mental/emotional state is	1	2	3
3. Overall my ability to handle stress is	1	2	3
4. Overall my enjoyment of life is	1	2	3
5. Overall my quality of life is	1	2	3