SOS
STRESS RECOVERY PROGRAM

4 Key Stressors Questionnaire

Patient Name: ______________________________ **Date:** ________________

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 In lammation)** 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?
- Do you frequently miss or delay meals?
- Do you frequently crave sugar or carbohydrates?
- Do you consume excessive sugar or refined carbohydrates?
- Are you diabetic or pre-diabetic?
- Do you regularly consume alcohol or caffeine? How much per day? ________
- Do you consume food within two hours before bedtime?
- Other ____

Mental and Emotional Stress

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

Sleep Cycle Disturbances

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

Inflammatory Imbalance or Chronic Pain

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

FOR OFFICE USE

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:

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Lifestyle Matrix RESOURCE CENTER

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