

Salem Health Midwives and OB/GYN

Stress Questions



PATIENT INFORMATION

Date: _____

Patient Name: _____ Date of Birth: _____

PLEASE ANSWER THE FOLLOWING QUESTION REGARDING YOUR LEVEL OF STRESS USING THE SCALE BELOW

1 = NO STRESS

2 = SOME STRESS

3 = MODERATE STRESS

4 = SEVERE STRESS

Circle the best answer.

How stressed/worried are you about finances?

1 2 3 4

How stressed/worried are you about money?

1 2 3 4

How stressed/worried are you about problems related to the family?

1 2 3 4

Are you having to move either now or in the future?

1 2 3 4

How stressed/worried are you about a recent loss of a loved one?

1 2 3 4

How stressed/worried are you about this pregnancy?

1 2 3 4

How stressed/worried are you about current abuse
(sexual, emotional or physical)?

1 2 3 4

How stressed/worried are you about problems with alcohol
or other drugs?

1 2 3 4

How stressed/worried are you about work problems?

1 2 3 4

Do you have problems related to friends?

1 2 3 4

How stressed/worried are you about feeling generally overloaded?

1 2 3 4

Within the past year, has anyone hit, slapped, kicked or otherwise
physically hurt you?

Yes No

Since your pregnancy has anyone hit, slapped, kicked or otherwise
physically hurt you?

Yes No

Within the last year has anyone forced you to have sex?

Yes No