

# Wellness & Quality of Life Survey



HEALTH, VITALITY AND COMMUNITY

Name: \_\_\_\_\_ Date: YY/MM/DD \_\_\_\_\_

Answer each of the questions below by circling the number that best describes your experience.

## I. Physical State

How often do you experience the following symptoms?

	Never	Rarely	Occasionally	Regularly	Constantly
1. 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. Fatigue or low energy.	1	2	3	4	5
4. Colds and flu.	1	2	3	4	5
5. Headaches (of any kind).	1	2	3	4	5
6. Nausea or constipation.	1	2	3	4	5
7. Menstrual discomfort.	1	2	3	4	5
8. Allergies or skin rashes.	1	2	3	4	5
9. Dizziness or lightheadedness.	1	2	3	4	5
10. Accidents or near accidents or falling or tripping.	1	2	3	4	5

## II. Mental/Emotional State

Rate the following questions with respect to frequency:

	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 anger outbursts.	1	2	3	4	5
4. Experience of depression or lack of interest.	1	2	3	4	5



Rate the following questions with respect to frequency:

	Never	Rarely	Occasionally	Regularly	Constantly
5. Being overly worried about small things.	1	2	3	4	5
6. Difficulty thinking or 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

### III. Stress Evaluation

Evaluate your stress relative to the following:

	None	Slight	Moderate	Considerable	Extensive
1. Family	1	2	3	4	5
2. Significant Other	1	2	3	4	5
3. Physical 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 wellbeing	1	2	3	4	5
10. Coping with daily problems	1	2	3	4	5

### IV. Life Enjoyment

Rate the following:

	None	Slight	Moderate	Considerable	Extensive
1. Openness to guidance to your "inner voice/feelings".	1	2	3	4	5
2. Experience of relaxation, ease or wellbeing.	1	2	3	4	5
3. Presence of positive feelings about yourself.	1	2	3	4	5
4. Interest in maintaining a healthy lifestyle (e.g., diet, fitness, etc.).	1	2	3	4	5



Rate the following:

	None	Slight	Moderate	Considerable	Extensive
5. Feeling of being open, aware and 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

## V. Overall Quality of Life

Evaluate your feelings relative to your quality of life

	Terrible	Unhappy	Dissatisfied	Mixed	Satisfied	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 coworkers.	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. Your physical appearance the way you look.	1	2	3	4	5	6	7
10. Your ability to adapt to change in your life.	1	2	3	4	5	6	7
11. Overall contentment with your life.	1	2	3	4	5	6	7