

Yale Stress Center- Assessment of Your Stress

Perceived Stress:

Indicate with a check how often you felt or thought a certain way during the last month.

1. In the last month, how often have you felt that you were unable to control the important things in your life?

0=never 1=almost never 2=sometimes 3=fairly often 4=very often

2. In the last month, how often have you NOT felt confident about your ability to handle your personal problems?

0=never 1=almost never 2=sometimes 3=fairly often 4=very often

3. In the last month, how often have you felt that things were NOT going your way?

0=never 1=almost never 2=sometimes 3=fairly often 4=very often

4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

0=never 1=almost never 2=sometimes 3=fairly often 4=very often

Scoring: Total up the scores for items 1-4 above. Higher scores denote greater current stress. Keep a log to compare your scores from month to month

Adapted from: Cohen, S., Kamarck, T., Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, 24, 385-396.

Physical signs and symptoms:

Check in with your body's stress signals. These can serve as warning signs that the situation you are dealing with is overwhelming, uncontrollable and highly stressful.

Have you felt any of the changes listed below in your body and mind when facing a highly stress situation:

1. Heart changes (heart quickens; heart beats faster; heart races; heart skips a beat; heart pounding; pain in chest)

0=no 1=yes

2. Changes in Breathing (breathing faster; breathing slower; gasping for air; shallow breathing; labored breathing)

___ 0=no ___ 1=yes

3. Stomach Changes (Cramps in stomach; stomach in a knot; butterflies in stomach; heavy feeling in stomach; sensation of having a bowel movement)

___ 0=no ___ 1=yes

4. Muscle tension (head pounding; headaches; tightness in face; tightness in jaw; feel tense all over; tension in back, neck, arms or legs; flushed face; tension in forehead; tension in shoulders)

___ 0=no ___ 1=yes

5. Fear and Anxiety (jitteriness; whole body is shaky; feel restless; irritable; hands trembling; want to run and escape)

___ 0=no ___ 1=yes

6. Sad and Depressed feelings (eyes watering; feeling choked up; lump in your throat; feel like crying; feeling empty, drained or hollow; deep intense pain sensation; hurts to be alive; tears come to your eyes; feelings are dulled)

___ 0=no ___ 1=yes

7. Anger feelings (clenched jaw; grit your teeth; clenched fists; eyes burning; blood rushes to your head; want to smash something; want to scream and strike someone)

___ 0=no ___ 1=yes

8. Sweat and Perspiration Changes (feel sweaty; sweat pours out; feel hot all over; palms are clammy; beads of perspiration; dry mouth)

___ 0=no ___ 1=yes

9. Sensations in Chest (sinking feeling in chest; constriction in the chest; heaviness in the chest)

___ 0=no ___ 1=yes

10. Cognitive/mental state Changes (losing focus and concentration; increased distraction; loss of memory and forgetfulness; loss of energy; fatigue or tiredness)

___ 0=no ___ 1=yes

11. Changes in urges or cravings and intake (increased urge for cigarettes, alcoholic drink; caffeine, comfort foods; overeating; overdrinking; loss of appetite)

___ 0=no ___ 1=yes

12. Sleep changes (insomnia; frequent waking; difficulty falling or staying asleep; early waking)

___ 0=no ___ 1=yes

13. Other changes (increased aches and pains in joints; increased frequency of colds, other signs specific to you)

___ 0=no ___ 1=yes

Scoring: The more changes you said yes to, the greater the impact stress is having on your body and mind.