

Name: _____

Quality of Life Survey

Date: _____

Directions - Tracking changes in a person's quality of life is the most important aspect of clinical assessment in your care. Please take the time to fill out this form completely and truthfully.

Answer all questions from 0 - 10. If you feel the question does not apply, think about it again.

Many men answer N/A to the question - incidence of menstrual discomfort, because they don't have a menstrual cycle. A better answer would be a 10 (never). Also, please total your score.

Have fun!

I. Physical State

Rate the following questions on a frequency scale of 0 - 10, (0 = constantly 3 = regularly 5 = sometimes 8 = rarely & 10 = never).

	Answer Here
1. Presence of physical pain (neck/back ache, sore arms/legs etc.).	
2. Feeling of tension, stiffness, or lack of flexibility in your spine.	
3. Incidence of fatigue or low energy.	
4. Incidence of colds and flu.	
5. Incidence of headaches (of any kind).	
6. Incidence of nausea or constipation.	
7. Incidence of menstrual discomfort.	
8. Incidence of allergies, eczema, or skin rashes.	
9. Incidence of dizziness or lightheadedness.	
10. Incidence of accidents, near accidents, or falling or tripping.	
TOTAL	

II. Mental/Emotional State

Rate the following questions on a frequency scale of 0 - 10, (0 = constantly 3 = regularly 5 = sometimes 8 = rarely & 10 = never).

	Answer Here
1. If pain is present, how distressed are you about it.	
2. Presence of negative or critical feelings about yourself.	
3. Experience of moodiness, temper, or angry outbursts.	
4. Experience of depression or lack of interest.	
5. Being overly worried about small things.	
6. Difficulty thinking, concentrating, or indecisiveness.	
7. Experience of vague fears or anxiety.	
8. Being fidgety or restless; difficulty sitting still.	
9. Difficulty falling or staying asleep.	
10. Experience of recurring thoughts or dreams.	
TOTAL	

III. Stress Evaluation

Evaluate your stress relative to the following, (0 = extreme, 2 = severe, 4 = much, 6 = some, 8 = little & 10 = none).

	Answer Here
1. Family.	
2. Significant Relationship.	
3. Health.	
4. Finances.	
5. Sex Life.	
6. Work.	
7. School.	
8. General well-being.	
9. Emotional well being.	
10. Coping with daily problems.	
TOTAL	

IV. Life Enjoyment

Rate the following questions on a degree scale of 0 – 10, (0 = not at all, 2 = rarely, 5 = sometimes, 8 = usually, 10 = extensive).

	Answer Here
1. Openness to guidance by your “inner voice/feelings.”	
2. Experience of relaxation, ease, or well being.	
3. Interest in maintaining a healthy lifestyle (e.g., diet, fitness, etc.).	
4. Feeling of being open and aware/connected when relating to others.	
5. Level of confidence in your ability to deal with adversity.	
6. Level of compassion for, and acceptance of others.	
7. Satisfaction with the level of recreation in your life.	
8. Incidence of feelings of joy and/or happiness.	
9. Level of satisfaction with your sex life.	
10. Time devoted to things you enjoy.	
TOTAL	

V. Overall Quality of Life (Woodruff and Conway, 1992)

Evaluate your feelings relative to the quality of your life on a scale of 0 – 10, (0 = terrible, 2 = unhappy, 3 = mostly dissatisfied, 5 = mixed, 7 = mostly satisfied, 8 = pleased, 10 = delighted).

	Answer Here
1. Your personal life.	
2. Your wife/husband or significant other.	
3. Your romantic life.	
4. Your job.	
5. Your co-workers.	
6. The actual work you do.	
7. Your handling of problems in your life.	
8. What you are actually accomplishing in your life.	
9. Your physical appearance – the way you look to others.	
10. Your self.	
11. The extent to which you can adjust to changes in your life.	
12. Your life as a whole.	
13. Overall contentment with your life.	
14. The extent to which your life has been what you wanted it to be.	
TOTAL	
Grand Total	

Are you becoming more compassionate and loving?	yes or no
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