Calgary Symptoms of Stress Inventory_____ID#_____

This questionnaire is designed to measure the different ways people respond to stressful situations. The following are sets of questions dealing with various physical, psychological, and behavioral responses. We are particularly interested in the frequency with which you may have experienced these stress-related symptoms **during the past week**.

1. Stress is often accompanied by a variety of emotions. During the **last week**, have you felt: (Mark one answer on each line.)

	Never (0)	Infrequently (1)	Sometimes (2)	Often (3)	Very Frequently (4)
a. Like life is entirely hopeless	_____	_____	_____	_____	_____
b. Unhappy and	_____	_____	_____	_____	_____

depressed c. Alone and sad	_____	_____	_____	_____	_____
d. That worrying gets you down	_____	_____	_____	_____	_____
e. Like crying easily	_____	_____	_____	_____	_____
f. That you wished you were dead	_____	_____	_____	_____	_____
g. Frightening thoughts keep coming back	_____	_____	_____	_____	_____
h. You suffer from severe nervous exhaustion	_____	_____	_____	_____	_____

2. Does it seem: (Mark one answer on each line.)

	Never (0)	Infrequently (1)	Sometimes (2)	Often (3)	Very Frequently (4)
a. You become mad or anger easily	_____	_____	_____	_____	_____
b. When you feel angry, you act angrily toward most everything	_____	_____	_____	_____	_____
c. You are easily annoyed and irritated	_____	_____	_____	_____	_____
d. That little things get on your nerves	_____	_____	_____	_____	_____
e. Angry thoughts about an irritating event keep bothering you	_____	_____	_____	_____	_____
f. You let little annoyances build up until you just explode	_____	_____	_____	_____	_____
g. Your anger is so great that you want to strike something	_____	_____	_____	_____	_____

3. Muscle tension is a common way of experiencing stress. During the past week, have you noticed excessive tension, stiffness, soreness or cramping in the muscles in your: (Mark one answer on each line.)

	Never (0)	Infrequently (1)	Sometime (2)	Often (3)	Very Frequently

					(4)
a. Shoulders	_____	_____	_____	_____	_____
b. Neck	_____	_____	_____	_____	_____
c. Back	_____	_____	_____	_____	_____
d. Jaw	_____	_____	_____	_____	_____
e. Forehead	_____	_____	_____	_____	_____
f. Eyes	_____	_____	_____	_____	_____
g. Hands or arms	_____	_____	_____	_____	_____
h. Have you experienced tension headaches?	_____	_____	_____	_____	_____

4. During the past week, have you noticed the following symptoms when not exercising: (Mark one answer on each line.)

	Never (0)	Infrequently (1)	Sometimes (2)	Often (3)	Very Frequently (4)
a. Thumping of your heart	_____	_____	_____	_____	_____
b. Rapid or racing heart beats	_____	_____	_____	_____	_____
c. Rapid breathing	_____	_____	_____	_____	_____
d. Irregular heart beats	_____	_____	_____	_____	_____
e. Difficulty breathing	_____	_____	_____	_____	_____
f. Pains in your heart or chest	_____	_____	_____	_____	_____

5. Do you experience: (Mark one answer on each line.)

	Never (0)	Infrequently (1)	Sometimes (2)	Often (3)	Very Frequently (4)
a. Difficulty in staying asleep at night	_____	_____	_____	_____	_____
b. Hot or cold spells	_____	_____	_____	_____	_____
c. Having to get up in the night to urinate	_____	_____	_____	_____	_____
d. Sweating excessively even in cold weather	_____	_____	_____	_____	_____

e. Having to urinate frequently	_____	_____	_____	_____	_____
f. Early morning awakening	_____	_____	_____	_____	_____
g. Flushing of your face	_____	_____	_____	_____	_____
h. Difficulty in falling asleep	_____	_____	_____	_____	_____
i. Breaking out in a cold sweat	_____	_____	_____	_____	_____

6. During the past week, have you experienced: (Mark one answer on each line.)

	Never (0)	Infrequently (1)	Sometimes (2)	Often (3)	Very Frequently (4)
a. Feeling faint	_____	_____	_____	_____	_____
b. Feeling weak	_____	_____	_____	_____	_____
c. Spells of severe dizziness	_____	_____	_____	_____	_____
d. Nausea	_____	_____	_____	_____	_____
e. Blurring of your vision	_____	_____	_____	_____	_____
f. Severe pains in your stomach	_____	_____	_____	_____	_____

7. Does it seem: (Mark one answer on each line.)

	Never (0)	Infrequently (1)	Sometimes (2)	Often (3)	Very Frequently (4)
a. You must do things very slowly to do them without	_____	_____	_____	_____	_____

mistakes					
b. You get directions and orders wrong	_____	_____	_____	_____	_____
c. Your thinking gets completely mixed-up when you have to do things quickly	_____	_____	_____	_____	_____
d. You have difficulty in concentrating	_____	_____	_____	_____	_____
e. You become suddenly frightened for no good reason	_____	_____	_____	_____	_____
f. You become so afraid you can't move	_____	_____	_____	_____	_____

8. During the past week, have you experienced: (Mark one answer on each line.)

	Never (0)	Infrequently (1)	Sometimes (2)	Often (3)	Very Frequently (4)
a. Colds	_____	_____	_____	_____	_____
b. Hoarseness	_____	_____	_____	_____	_____
c. Colds with complications (e.g. Bronchitis)	_____	_____	_____	_____	_____
d. Nasal stuffiness	_____	_____	_____	_____	_____
e. Having to clear your throat often	_____	_____	_____	_____	_____
f. Sinus headaches	_____	_____	_____	_____	_____