Health Distress Index

Form HDI-40-C

Name or I.D.: _____ Date : _____

	Symptoms or Experiences During the Week	Degree or Frequency of Experience				
	Place a "✔" mark in the column that applys to you:	Never	Low	Middle	High	Highest
1.	Difficulty falling asleep at night					
2.	Difficulty remaining asleep at night					
3.	Felt sleep duration was inadequate or insufficient					
4.	Felt tired, drowsy, or fatigued during the day					
5.	Felt full of energy and vitality during the day					
6.	Felt good, happy, elated					
7.	Took time to engage in fun or enjoyable activities					
8.	Socialized with people you like to be with					
9.	Felt confident or optimistic about things					
10.	Able to work productively and accomplish tasks					
11.	Back pain					
12.	Headaches					
13.	Shoulder tension or stiff neck					
14.	Aches or stiffness in hands, feet, arms, or legs					
15.	Chest pain or tightness or tenderness in breasts					
16.	Abdominal pain or discomfort					
17.	Nausea or vomiting					
18.	Constipation, diarrhea, or flatulence (gas)					
19.	Coughing or difficulty breathing					
20.	Felt ill, feverish, sick, or malaise					
21.	Sore throat, runny nose, or swollen lymph glands					
22.	Felt dizzy, weak, or faint					
23.	Undereating or low appetite					
24.	Cold or numb feelings in hands or feet					
25.	Pounding or rapid heart beats or heart palpitations					
26.	Sweating not due to exercise or external heat					
27.	Trembling, jittery, or shaking					
28.	Felt tense, agitated, frustrated, or restless					
29.	Nervous, anxious, or scared					
30.	Worried about finances or work/school pressures					
31.	Fear of losing control or being overwhelmed					
32.	Difficulty concentrating or making decisions					
33.	Excessive overeating or binge eating					
34.	Felt inadequate, worthless, or low self-esteem					
35.	Felt down, depressed, or discouraged about future					
36.	Felt lonely, isolated, or withdrawn					
37.	Felt sad, tearful, or cried easily					
38.	Felt little interest or satisfaction in doing things					
39.	Felt irritable, annoyed, or resentful					
40.	Have self-critical, negative thoughts unable to stop					

HCA, PMB 2657, 8033 Sunset Blvd., L.A., CA 90046 Tel: (323) 656 - 2084 E-mail: hca-la@worldnet.att.net Web:www.auriculotherapy.com

Instructions for Health Distress Index (HDI-40)

Overview: The purpose of this survey is to have you personally evaluate your typical symptoms of stress, pain, tension, and mood changes during the week.

Ratings: For items #1 to #40, please rate your most typical daily experience for each of the items indicated, using a subjective rating scale which combines the degree, intensity, frequency and duration of that symptom. The numeric values of the rating are as follows :

"**4**" for a Highest Level of the presence of that symptom or experience;
"**3**" for a High Level of the presence of that symptom or experience;
"**2**" for a Moderate Level of the presence of that symptom or experience;
"**1**" for a Mild Level of the presence of that symptom or experience;
"___ " (leave blank) for None of that experience.

Example Ratings **:** These items are very subjective. You should be compare your rating to the range of such experiences that you have had in your life. A rating of "4", for example, would be reserved for the worst time that you have ever had in either falling asleep or remaining asleep, the most severely painful headache or back pain that you have ever had, the most bothersome experience of feeling nervous or depressed that you can remember, or the best times of feeling good or working productively that you can remember. Ratings of 3, 2, and 1 indicate progressivley less intense or less frequent degrees of that symptom or experience.

HCA, PMB 2657, 8033 Sunset Blvd., L.A., CA 90046 Tel: (323) 656 - 2084 E-mail: hca-la@worldnet.att.net Web:www.auriculotherapy.com