Self-Assessment: Relaxation

1. How do you presently cope with stressors?
   a. 
   b. 
   c. 
   d. 

2. Do you ever take time out and do nothing?   Yes____   No____

3. Do you find it difficult to relax?   Yes____  No____

4. Do you have feelings of guilt when you take time to do nothing or relax?
   Yes _____  No____

5. Do you have deeply etched wrinkle lines on your forehead, around your mouth or
   eyes?   Yes____  No____

6. Do you clench your jaw or grind your teeth habitually?   Yes_____  No_____ 

7. What is your formal method of relaxing?
   a. 
   b. 
   c. 
   d. 

8. During an average day do you experience:
   a. Shortness of breath?   Yes_____  No____
   b. Rapid heartbeat?   Yes_____  No____
   c. Tightened stomach muscles?   Yes_____  No____
   d. Trembling hands?   Yes_____  No____
   e. Tightened neck and shoulder muscles?   Yes_____  No____
   f. Other signs of tension?   Yes_____  No____

9. Are any of your muscle groups (especially arms, legs and shoulders) chronically 
tensed?   Yes_____  No____

10. Can you turn off the pressures of the day easily?   Yes_____  No____

11. Would the people who live and work around your support a relaxation program?
   Yes_____  No_____