Anxiety Questionnaire

Date: _____/_____/_____ Patient Name: _____

Patient Date of Birth: _____/_____/_____ Age _____ Sex ☐ Yes ☐ No

Questions	Yes	No
1) Do you feel that you worry excessively about many things?	☐	☐
2) Do you experience sensations of shortness of breath, palpitations or shaking while at rest?	☐	☐
3) Do you have a fear of losing control of yourself or of "going crazy"?	☐	☐
4) Do you avoid social situations because of feeling of fear?	☐	☐
5) Do you have specific fears of certain objects? (Example: animals, knives, etc)	☐	☐
6) Do you feel afraid that you will be in a place or a situation from which you feel that you will not be able to escape?	☐	☐
7) Does the idea of leaving home frighten you?	☐	☐
8) Do you have recurrent thoughts or images in your head that refuses to go away?	☐	☐
9) Do you feel compelled to perform certain behaviors repeatedly?	☐	☐
10) Do you persistently relive an upsetting event from the past?	☐	☐
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