

## **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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