

Adult Anxiety Checklist

Name: _____ Date: _____

INSTRUCTIONS: Pick out the **one answer** that best describes the way you have been feeling during the past two weeks, including today. Circle the number of the correct answer. Please do not choose more than one number for each statement. Respond to each situation as best you can: if it's not a problem at all; if it's a mild problem, that is bothersome but doesn't interfere with daily activities; or a moderate problem, that does interfere with daily activities; or a severe problem, that makes it very hard to have a normal day at all.

Do you experience or feel the following?	Not a Problem	Mild	Moderate	Severe
1. Heart Racing	0	1	2	3
2. Sweating	0	1	2	3
3. Trembling/Shaking	0	1	2	3
4. Dry Mouth	0	1	2	3
5. Difficulty Breathing	0	1	2	3
6. Chest Pain/Discomfort	0	1	2	3
7. Nausea	0	1	2	3
8. Abdominal Pain/Discomfort	0	1	2	3
9. Dizzy/Unsteady/Lightheaded	0	1	2	3
10. Hot Flushes	0	1	2	3
11. Numbness/Tingling	0	1	2	3
12. Headache	0	1	2	3
13. Muscle Tension	0	1	2	3
14. Difficulty Swallowing	0	1	2	3
15. Lump in Throat	0	1	2	3
16. Feeling of Choking	0	1	2	3
17. Fear of Dying	0	1	2	3
18. Fear of Losing Control	0	1	2	3
19. Fear of Worst Happening	0	1	2	3
20. Scared/Uneasy Feeling	0	1	2	3
21. Inability to Relax	0	1	2	3
22. Feeling Keyed Up/On Edge	0	1	2	3
23. Irritable	0	1	2	3
24. Difficulty Falling Asleep	0	1	2	3
25. Difficulty Concentrating	0	1	2	3

MEAN ITEM SCORE		TOTAL SCORE	
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