Anxiety Checklist

Name: _____ Date:_____

The following list of symptoms will help us determine your level of Anxiety. Please indicate the frequency of each listed symptom.

Symptom	Never	Seldom	Sometimes	Often	Always
I am worrying a lot.					
My heart pounds or races.					
I have sweaty hands.					
I have a difficult time getting a deep breath.					
I have nausea or stomach aches.					
I have headaches.					
I am fatigued.					
I have a sense of dread.					
I am fearful about the future.					
I have difficulty concentrating.					
I feel tense or jumpy.					
I am more irritable than usual.					
I am more restless than usual.					
I am watchful for signs of danger.					
My mind goes "blank".					
I have obsessive thoughts.					
I practice compulsive behaviors.					
I am having nightmares.					
I experience "flashbacks" of previous traumas.					
I am frightened of _____.					
I am afraid of being in social situations.					
I have a difficult time trusting others.					

This questionnaire is designed to help you and your therapist better understand your experiences. It is not designed for diagnosis. For a correct diagnosis, you must seek professional help from a licensed mental health professional.

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