Name:_____ Date:_____

ANXIETY SCALE

INSTRUCTIONS: This scale includes questions about the symptoms of anxiety. For each item please indicate how well it describes you during the PAST WEEK, INCLUDING TODAY. Circle the number in the columns next to the item that best describes you.

0=not at all true 1=rarely true 2=sometimes true 3=often true 4=almost always true

During the PAST WEEK, INCLUDING TODAY....

1. I felt nervous or anxious 0 1 2 3 4
2. I worried a lot that something bad might happen 0 1 2 3 4
3. I worried too much about things 0 1 2 3 4
4. I was jumpy and easily startled by noises 0 1 2 3 4
5. I felt "keyed up" or "on edge" 0 1 2 3 4
6. I felt scared 0 1 2 3 4
7. I had muscle tension or muscle aches 0 1 2 3 4
8. I felt jittery 0 1 2 3 4
9. I was short of breath 0 1 2 3 4
10. My heart was pounding or racing 0 1 2 3 4
11. I had cold, clammy hands 0 1 2 3 4
12. I had a dry mouth 0 1 2 3 4
13. I was dizzy or lightheaded 0 1 2 3 4
14. I felt sick to my stomach (nauseated) 0 1 2 3 4
15. I had diarrhea 0 1 2 3 4
16. I had hot flashes or chills 0 1 2 3 4
17. I urinated frequently 0 1 2 3 4
18. I felt a lump in my throat 0 1 2 3 4
19. I was sweating 0 1 2 3 4
20. I had tingling feelings in my fingers or feet 0 1 2 3 4