

Anxiety Symptom Questionnaire

Use for generalized anxiety, panic, social anxiety, phobias, health anxiety, or stress-related concerns.

Patient name:	_____	Date of birth:	_____
Date completed:	_____	Appointment date:	_____

During the past 2 weeks, how often have you experienced the following?

Symptom or experience	Not at all	Several days	More than half	Nearly every day
Feeling nervous, anxious, tense, or on edge	☐	☐	☐	☐
Difficulty controlling worry	☐	☐	☐	☐
Worrying about many different things	☐	☐	☐	☐
Difficulty relaxing	☐	☐	☐	☐
Restlessness or feeling keyed up	☐	☐	☐	☐
Becoming easily irritated	☐	☐	☐	☐
Fear that something terrible may happen	☐	☐	☐	☐
Panic episodes with sudden intense fear or physical symptoms	☐	☐	☐	☐
Avoiding places, people, activities, driving, travel, or appointments because of anxiety	☐	☐	☐	☐

How difficult have these symptoms made work, school, home responsibilities, or relationships?

☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Panic and avoidance details

Question	No	Yes	Unsure
Do symptoms peak suddenly within minutes?	☐	☐	☐
Do episodes include chest discomfort, shortness of breath, dizziness, shaking, sweating, nausea, numbness, or fear of losing control?	☐	☐	☐
Do you worry about having another episode?	☐	☐	☐
Have you changed your behavior or avoided situations because of panic?	☐	☐	☐

Question	No	Yes	Unsure
Have medical causes such as thyroid disease, heart rhythm problems, asthma, medication effects, caffeine, or substances been considered?	☐	☐	☐

Main worries, triggers, or avoided situations:

What do you do to feel safer or reduce anxiety?
