Rogers Memorial Hospital

Anxiety Disorders Screening Tool

Name:_______________________________________ Date:_________________

Address: ____ City, State, Zip: _________________________________

Phone Number: (______)_______________ Age: ______ Gender: M F

SECTION I

1. Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells peak within 10 minutes? [ ]Yes [ ] No*
   If answers to question 1 are no, skip to Section II.

2. At any time in the past, did any of these spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner? [ ]Yes [ ] No

3. Have you ever had one such attack followed by a month or more of persistent fear of having another attack, or worries about the consequences of the attack? [ ] Yes [ ] No

SECTION II

1. In the past month, were you fearful or embarrassed being watched, being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public or with others, writing while someone watches or being in social situations? [ ] Yes [ ] No*
   If answers to question 1 are no, skip to Section III.

2. Is this fear excessive or unreasonable? Do you fear these situations so much that you avoid them or suffer through them? [ ] Yes [ ] No

SECTION III

1. Have you ever experienced or witnessed or had to do deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? [ ] Yes [ ] No*
   If answer to question 1 is no, skip to Section IV.

2. During the past month, have you re-experienced the event in a distressing way (such as dreams, intense recollections, flashbacks or physical reactions)? [ ] Yes [ ] No

SECTION IV

1. Have you worried excessively or been anxious about two or more things (for example, finances, children's well being, misfortune) over the past six months? More than most others would? Are these worries present most days? [ ] Yes [ ] No*
   If answers to question 1 are no, skip to Section V.

2. Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing? [ ] Yes [ ] No

SECTION V

On a scale of zero to ten (with zero being not at all and ten being extremely) please rate to what extent you have emotional symptoms…

1. Disrupted your <u>work</u> in the last month:

   0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10

2. Disrupted your <u>social life</u> in the last month:

   0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10

3. Disrupted your <u>family or home responsibilities</u> in the last month:

   0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10