Name:

ANXIETY INVENTORY

Using the scale below please rate each item to show how much it has been a problem for you during the past two weeks:

0-not a problem **1-occasionally a problem** **2-often a problem** **3-definitely a problem**

	Date ____	Date ____	Date ____	Date ____
1. Anxious/nervous	______	______	______	______
2. Worry too much about things	______	______	______	______
3. Restless	______	______	______	______
4. Insomnia/difficulty sleeping	______	______	______	______
5. Tired/fatigued	______	______	______	______
6. Difficulty concentrating/distracted	______	______	______	______
7. Decreased memory/forgetful	______	______	______	______
8. Difficulty making decisions	______	______	______	______
9. Irritable/easily angered	______	______	______	______
10. Increased muscle tension	______	______	______	______
11. Shortness of breath/difficulty breathing	______	______	______	______
12. Increased heart rate	______	______	______	______
13. Upset stomach	______	______	______	______
14. Sweating	______	______	______	______
15. Social isolation/withdrawal	______	______	______	______
TOTAL:	______	______	______	______