Anxiety Self-Assessment

Rate yourself in terms of how you experience the following from 0-4 (0 being never and 4 being extreme experience):

1. _____ Nervousness or shaking inside.
2. _____ Nausea, stomach pain, or discomfort.
3. _____ Feeling scared suddenly and without any reason.
4. _____ Palpitations or feeling your heart beat faster.
5. _____ Significant difficulty trying to fall asleep.
6. _____ Difficulty relaxing.
7. _____ Tendency to startle easily.
8. _____ Tendency to be easily irritable or bothered.
9. _____ Inability to free yourself of obsessive thoughts.
10. _____ Tendency to awaken early in the morning and not go back to sleep.
11. _____ Feeling nervous when alone.

If there are any other symptoms that you experience, please list them:

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