DASHOMETRICS
EMPOWERING PSYCHOLOGICAL TOOLS

ANXIETY SPECTRUM-I

Name _____

Date _____

ANXIETY SPECTRUM-1

Please answer these questions based on whether you have experienced any of these symptoms over the preceding week.

Never = 0, Occasionally = 1, Moderately = 2 and Almost all of the time = 3

	Never	Occasionally	Moderately	Almost all the time
1. Persistent muscle tension, tingling, trembling, numbness, sweaty palms, feeling warm or flush, butterflies in stomach, weakness in legs, shortness of breath, chest pain or heart palpitations ***(circle all of these that apply)***	0	1	2	3
2. Sense of agitation or restlessness	0	1	2	3
3. Physical fatigue or exhaustion	0	1	2	3
4. Loss of appetite or eating too much *(circle which)*	0	1	2	3
5. Difficulty sleeping or sleeping too much *(circle which)*	0	1	2	3
6. Difficulty concentrating or mind going blank *(circle which)*	0	1	2	3
7. Worrying about	0	1	2	3
8. Sense of dread like something will go wrong or something bad is about to happen	0	1	2	3
GENERAL ANXIETY SUBSCORE : _____				
9. Nightmares, flashbacks or intrusive thoughts about something that has happened in the past	0	1	2	3
10. Obsessive thoughts	0	1	2	3
11. A strong drive for compulsive or repetitive actions	0	1	2	3
12. Fear of social situations	0	1	2	3
13. Fear of leaving your residence or place of safety	0	1	2	3
14. Anxiety that is so high you feel panicked and it is difficult to breathe	0	1	2	3

SPECIAL ANXIETY FORMS SUBSCORE : _____

TOTAL SCORE _____

As far as what people know about me, my life is: ***(circle best answer)***

Very open Somewhat open In the middle Somewhat secretive Very secretive