DASHOMETRICS
EMPOWERING PSYCHOLOGICAL TOOLS

This instrument relies on honest responses and should only be used in conjunction with a more complete evaluation by a trained professional.

ANXIETY SPECTRUM-1

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

FOR DEMONSTRATION ONLY

	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 a lot	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 : ________

	Never	Occasionally	Moderately	Almost all the time
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

FOR DEMONSTRATION ONLY

FOR DEMONSTRATION ONLY

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

Copyright 2016, Dashometrics, LLC. Stanley Thiele, MA, LP. All rights reserved.

3/28/2016