Check the box to the right of each issue that applies to you in the last two weeks.

ISSUE	Never	Monthly Some of the time	Weekly Much of the time	Daily All the time
Feeling anxious, nervous, worrisome, or fearful:				
Feeling that things around you are unreal or strange:				
Feeling detached from part of your body or all of your body:				
Sudden, unexpected panic spells:				
Feeling of that something bad is going to happen or apprehension:				
Feeling tense, stressed, uptight, or on the edge:				
Trouble concentrating:				
Racing thoughts:				
Scary or troubling daydreams or fantasies:				
Feeling that you are on edge of losing control:				
Feeling that you are going crazy or going to go crazy:				
Fears of fainting or passing out:				
Fears of physical illnesses, heart attacks or that you're going to die:				
Concerns about looking foolish or inadequate:				
Fears of being alone, isolated, or abandoned:				
Concerned about criticism or disapproval:				
Fears that something terrible is about to happen:				
Skipping, racing, pounding of the heart:				
Pain, pressure, tightness in chest:				
Tingling or numbness in toes or fingers:				
Butterflies or discomfort in stomach:				

Constipation or diarrhea:				
Restlessness or jumpiness:				
Tight, tense muscles:				
Sweating not brought on by heat:				
A lump in the throat:				
Trembling or shaking:				
Rubbery or "jelly" legs:				
Feeling dizzy, lightheaded, or off balance:				
Choking or smothering sensations of difficulty breathing:				
Headaches or pains in the neck or back:				
Hot flashes or cold chills:				
Feeling tired, weak, or easily exhausted:				

Have these problems caused you:
___ to miss work or be late to work
___ be less productive at work
___ other work problems _____
___ to have arguments with family or friends or become isolated from family or friends
___ to not take good care of myself
___ to abuse drugs or alcohol
___ to have trouble functioning as well as I usually do

Overall, these problems have caused me:
___ no difficulties at all
___ mild difficulties
___ made things very difficult (___or somewhere in between mild and very difficult)
___ made things extremely difficult

_____ _____
Your signature Date

Your Name: _____ Today's Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Issues	Not at all	Several days	More than half of the days	Nearly every day
I have less interest in doing things I look forward to, or I do not find things as enjoyable as I usually do?	0	1	2	3
I have felt sad, depressed, irritable, or hopeless?	0	1	2	3
I have trouble falling asleep, staying asleep, or I sleep too much?	0	1	2	3
I feel tired or have less energy than usual?	0	1	2	3
I have lost my appetite, or I have been over eating to the point of weight loss or gain?	0	1	2	3
I feel guilty, worthless or like a failure?	0	1	2	3
I have trouble thinking, concentrating, or making decisions?	0	1	2	3
I have been moving slower, or I have been fidgety, so much so that other people could have noticed?	0	1	2	3
I have had thoughts of death, thoughts that life is not worth living, that I would be better off dead, or I have thoughts of killing myself?	0	1	2	3
Do not total your scores, please return to staff.		____ +	____ +	____ =
			Total	

Have these problems caused you:
___ to miss work or be late to work
___ be less productive at work
___ other work problems _____
___ to have arguments with family or friends or become isolated from family or friends
___ to not take good care of myself
___ to abuse drugs or alcohol
___ to have trouble functioning as well as I usually do

Overall, these problems have caused me:
___ no difficulties at all
___ mild difficulties
___ made things very difficult (___or somewhere in between mild and very difficult)
___ made things extremely difficult

_____ _____
Your signature Date