Office of Peggy Demetriou **ARNP, FNP-BC**

ANXIETY SCALE

Name: _____ **Date: _____**

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

Circle to indicate your answer.

	Not at all	Several Days	More Than Half the Days	Nearly Every Day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3
COLUMN TOTALS	_____ +	_____+	_____+	___

Total = _____

Please add any further information about your anxiety

If you are on medication, is it helping to address some of these concerns? Please explain.

_____

_____

_____

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult