## **Anxiety Journal**

Name:	
Date:	Time:
Current anxiety level	
Rate your anxiety from 1-10:	
1 2 3 4 5	6 7 8 9 10
(1 = completely calm, 10 = most anxious you've ever felt)	
Physical sensations	
Check all that apply:	
Rapid heartbeat	Nausea
Shallow breathing	Dizziness
Sweating	Trembling
Muscle tension	Other:
Current situation	
What's happening right now?	
Where are you?	
Who are you with?	
Thought patterns	
What thoughts are going through your mind?	