

# Beck's Anxiety Inventory

Patient Name: \_\_\_\_\_ Date Assessed: \_\_\_\_\_

**Instructions:** Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by selecting the statement in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much	Moderately - it wasn't pleasant at times	Severely - it bothered me a lot
Numbness or tingling	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Feeling hot	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Wobbliness in legs	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Unable to relax	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Fear of worst happening	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Dizzy or lightheaded	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Heart pounding/racing	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Unsteady	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Terrified or afraid	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Nervous	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Feeling of choking	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Hands trembling	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Shaky/unsteady	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Fear of losing control	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Difficulty in breathing	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
Fear of dying	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>

Scared 0  1  2  3

Indigestion 0  1  2  3

Faint/lightheaded 0  1  2  3

Face flushed 0  1  2  3

Hot/cold sweats 0  1  2  3

Total Score:

Additional Comments:

Clinician's full name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date signed: \_\_\_\_\_