

The Stress & Anxiety Management Program *Transforming Anxiety into Personal Power*

Stress & Anxiety Self Evaluation Form Part I

Stress & Anxiety Diary

| Over the past week how much: | not at all | a little | moderately | markedly | extremely |
|--|-------------------|-----------------|-------------------|-----------------|------------------|
| 1. have you worried excessively and been anxious about several things? | 1 | 2 | 3 | 4 | 5 |
| 2. difficulty did you have controlling the worries or how much do they interfere with your ability to focus on what you are doing? | 1 | 2 | 3 | 4 | 5 |
| 3. did you feel restless, keyed up or on edge? | 1 | 2 | 3 | 4 | 5 |
| 4. did you feel tense? | 1 | 2 | 3 | 4 | 5 |
| 5. did you feel tired, weak or exhausted easily? | 1 | 2 | 3 | 4 | 5 |
| 6. difficulty did you have concentrating or find your mind going blank? | 1 | 2 | 3 | 4 | 5 |
| 7. irritability did you feel? | 1 | 2 | 3 | 4 | 5 |
| 8. difficulty did you have sleeping (difficulty falling asleep, waking up in the middle of the night, early morning waking or sleeping excessively)? | 1 | 2 | 3 | 4 | 5 |

The Stress & Anxiety Management Program *Transforming Anxiety into Personal Power*

Stress & Anxiety Self Evaluation Form Part II

The Different Stress & Anxiety Conditions: A Brief Overview

There are several types of anxiety disorders. The following questions may help you identify the particular anxiety disorder you are dealing with.

a) When you were anxious over the past 6 months, did you, most of the time:

i) Feel restless, keyed up or on edge?

| | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
|--------------------------|-----|--------------------------|----|

ii) Feel tense

| | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
|--------------------------|-----|--------------------------|----|

iii) Feel tired, weak or exhausted easily?

| | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
|--------------------------|-----|--------------------------|----|

iv) Have difficulty concentrating or find your mind going blank?

| | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
|--------------------------|-----|--------------------------|----|

v) Feel irritable?

| | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
|--------------------------|-----|--------------------------|----|

vi) Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning waking or sleeping excessively)?

| | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
|--------------------------|-----|--------------------------|----|

If you answered yes to 3 or more of the above questions, you may have Generalized Anxiety Disorder (GAD).

b) Do you get anxiety attacks (periods of extreme panic) that occur out of the blue?

| | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
|--------------------------|-----|--------------------------|----|

c) Did you have at least one anxiety attack in the past month?

| | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
|--------------------------|-----|--------------------------|----|

If you answered yes to (b) or (c), you may be suffering from Panic Disorder.

d) Does fear of a panic attack cause you to avoid certain situations?

| | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
|--------------------------|-----|--------------------------|----|

If you answered yes to (d), you may be dealing with agoraphobia.

e) Do you feel anxious in social situations or avoid situations for fear of being humiliated or embarrassed?

| | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
|--------------------------|-----|--------------------------|----|

If you answered yes to (e), you may be suffering from social phobia.

f) Do you fear a specific object (e.g., insects, animals, bridges) or situation (e.g., flying, heights, dental visits)?

| | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
|--------------------------|-----|--------------------------|----|

If you answered yes to (f), you might be experiencing specific phobia. Most people have a phobia the question is whether it affects your ability to function normally.

g) Do you have anxiety related to a traumatic event (e.g., personal trauma, personal traumatic experience, combat, sexual abuse, car crash, natural disaster) that has lasted more than one month and involves flashback, dreams or memories?

| | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
|--------------------------|-----|--------------------------|----|

If you answered yes to (g), it is likely that you are suffering from post traumatic stress disorder.

h) Do you have recurring, unwanted thoughts such as preoccupation with germs, fear of forgetting to lock your door or harming someone close to you.

| | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
|--------------------------|-----|--------------------------|----|

i) Do you perform rituals such as washing your hands, repeatedly checking locks, etc.?

| | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
|--------------------------|-----|--------------------------|----|

If you answered yes to (h) and/or (i), you may be suffering from Obsessive-