

# THE BURNS ANXIETY INVENTORY

<p><b>INSTRUCTIONS:</b> The following is a list of symptoms that people sometimes have. Put a check ( <input type="checkbox"/> ) in the space to the right that best describes how much that symptom or problem has bothered you during this past week.</p> <p style="text-align: center;"><b>SYMPTOM LIST</b></p>	0-NOT AT ALL	1-SOMEWHAT	2-MODERATELY	3-A LOT
--	--------------	------------	--------------	---------

## CATEGORY I: ANXIOUS FEELINGS

1.	Anxiety, Nervousness, Worry, and Fear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Feeling that things around you are strange, unreal or foggy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Feeling detached from all or part of your body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Sudden unexpected panic spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Apprehension or a sense of impending doom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Feeling tense, stressed, "uptight," or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## CATEGORY II: ANXIOUS THOUGHTS

7.	Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Racing thoughts or your mind jumps from one thing to the next.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Frightening fantasies or daydreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Feeling that you're on the verge of losing control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Fears of cracking up or going crazy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Fears of fainting or passing out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Fears of physical illness or heart attacks or dying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Concerns about looking foolish or inadequate in front of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Fears of being alone, isolated, or abandoned	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16.	Fears of criticism or disapproval	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	Fears that something terrible is about to happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**CAEGORY III: PHYSICAL SYMPTOMS**

18.	Skipping or racing or pounding of the heart (palpitations)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	Pain, pressure, or tightness in the chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	Tingling or numbness in the toes or fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	Butterflies or discomfort in the stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	Constipation or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	Restlessness or jumpiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.	Tight, tense muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25.	Sweating not brought on by heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.	A lump in the throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27.	Trembling or shaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28.	Rubbery or "jelly" legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29.	Feeling dizzy, lightheaded, or off balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30.	Choking or smothering sensations or difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31.	Headaches or pains in the neck or back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32.	Hot flashes or cold chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33.	Feeling tired, weak, or easily exhausted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Add up your total score for the 33 symptoms and record it here.					
<b>DATE:</b>					

<b>TOTAL SCORE</b>	<b>DEGREE OF ANXIETY</b>	<b>YOUR SCORE</b>
0-4	Minimal or No Anxiety	
5-10	Borderline Anxiety	
11-20	Mild Anxiety	
21-30	Moderate Anxiety	
31-50	Severe Anxiety	
51-99	Extreme Anxiety or Panic	