ANXIETY SYMPTOMS QUESTIONNAIRE (ASQ)

Please read each item and fill each box with the number in the scales below that best describes your experience regarding the Intensity(A) and Frequency (B) of these symptoms:

A. *USE THIS SCALE TO COMPLETE COLUMN (A) BELOW*

How INTENSE or BOTHERSOME the symptom(s) have been in the past week, using the following scale:

0 1 2 3 4 5 6 7 8 9 10

None — Extreme distress

Mild (1–3) Moderate (4–6) Severe (7–9)

B. *USE THIS SCALE TO COMPLETE COLUMN (B) BELOW*

How FREQUENTLY have you experienced the symptom(s) in the past week, using the following scale:

0 1 2 3 4 5 6 7 8 9 10

Never — All the time

Occasionally (1–3) Often (4–6) Usually (7–9)

	A	B
IN THE PAST WEEK:	**INTENSITY (0 to 10)**	**FREQUENCY (0 to 10)**
1. Anxiety		
2. Nervousness		
3. Worrying		
4. Irritability		
5. Muscle Tension or Tightness		
6. Trouble Relaxing		
7. Trouble Falling or Staying Asleep *(Rate the most troublesome symptom)*		
8. Fatigue or Lack of Energy		
9. Problems with Concentration or Attention		
10. Trouble Remembering Things		
11. Shortness of Breath, Chest Tightness or Pain, Pounding/Skipping/Racing Heartbeat *(Rate the most troublesome symptom)*		
12. Stomach Upset, Nausea, Constipation, Diarrhea, or Irritable Bowels *(Rate the most troublesome symptom)*		
13. Dizziness, Lightheadedness, Headaches, Trembling or Shakiness *(Rate the most troublesome symptom)*		
14. Numbness, Tingling, Excessive Sweating, Flushing or Frequent Urination *(Rate the most troublesome symptom)*		
15. Feeling Restless, Keyed Up, or On Edge		
16. Anticipating or Fearing Something Bad Might Happen		
17. Trouble Functioning at Home, Work, or Socially Due to Anxiety *(Rate the most troublesome symptom)*		