Circle one number for each item that best describes how much you have experienced each symptom over the past week.

	Not at all	Sometimes	Frequently	Most of the time
1. Feeling nervous	0	1	2	3
2. Frequent worrying	0	1	2	3
3. Trembling, twitching, feeling shaky	0	1	2	3
4. Muscle tension, muscle aches, muscle soreness	0	1	2	3
5. Restlessness	0	1	2	3
6. Easily tired	0	1	2	3
7. Shortness of breath	0	1	2	3
8. Rapid heartbeat	0	1	2	3
9. Sweating not due to the heat	0	1	2	3
10. Dry mouth	0	1	2	3
11. Dizziness or light-headedness	0	1	2	3
12. Nausea, diarrhea, or stomach problems	0	1	2	3
13. Frequent urination	0	1	2	3
14. Flushes (hot flashes) or chills	0	1	2	3
15. Trouble swallowing or "lump in throat"	0	1	2	3
16. Feeling keyed up or on edge	0	1	2	3
17. Quick to startle	0	1	2	3
18. Difficulty concentrating	0	1	2	3
19. Trouble falling or staying asleep	0	1	2	3
20. Irritability	0	1	2	3
21. Avoiding places where I might be anxious	0	1	2	3
22. Frequent thoughts of danger	0	1	2	3
23. Seeing myself as unable to cope	0	1	2	3
24. Frequent thoughts that something terrible will happen	0	1	2	3

Score (of total circled numbers)