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# *Written* ANXIETY AND PHOBIA TEST

**Cover Page for Office Use Only!!!**

**Excerpt from A SPECIAL HEALTH REPORT FROM HARVARD MEDICAL SCHOOL**
**Harvard Health Publications**

**TEST RESULTS:**

| | |
|---|---|
| Symptoms of Separation Anxiety Disorder: | ___**yes** ___ **no** ___ **sometimes** (out of 8 quest.) |
| Symptoms of Panic Attack: | ___**yes** ___ **no** ___ **sometimes** (out of 3 quest.) |
| Symptoms of Panic Disorder: | ___**yes** ___ **no** ___ **sometimes** (out of 5 quest.) |
| Symptoms of Specific Phobia: | ___**yes**___ **no** ___ **sometimes** (out of 4 quest.) |
| Number of Possible Phobias: | ___ (out of possible 33 phobias) |
| Symptoms of Social Phobia: | ___**yes** ___ **no** ___ **sometimes** (out of 3 quest.) |
| Signs of Social Phobia: | ___**yes** ___ **no** ___ **sometimes** (out of 6 quest.) |
| Symptoms of OCD: | ___**yes** ___ **no** ___ **sometimes** (out of 3 quest.) |
| Symptoms of Post-traumatic Stress Disorder | ___**yes** ___ **no** ___ **sometimes** (out of 5 quest.) |
| Sings of Post-traumatic Stress Disorder | ___**yes** ___ **no** ___ **sometimes** (out of 8 quest.) |
| Generalized Anxiety Disorder | ___**yes** ___ **no** (out of 6 quest.) |
| Symptoms of Generalized Anxiety Disorder | ___**yes** ___ **no** (out of 6 quest.) |

**Name:** _________________________________ **DOB:** ____/____/____**Date**____/____/____

## SYMPTOMS OF SEPARATION ANXIETY DISORDER:

*Many children become anxious when they must be away from home or from their parents, but those with separation anxiety do so regularly and excessively. They worry lasts for at least 4 weeks and causes significant distress or even impairs the child's ability to function normally. Separation anxiety starts before 18. It consists of at least 3 of the following symptoms.*

1. Yes No Sometimes Excessive distress when away from home, separated from loved once, or anticipates such a separation.

Time / period of symptom appearance: ___________________________________________

2. Yes No Sometimes Extreme worry about losing loves ones, or having them come to harm.

Time / period of symptom appearance: ___________________________________________

3. Yes No Sometimes Persistent, excessive worry that a terrible event will lead to a separation from loved ones, example, getting lost or being kidnapped.

Time / period of symptom appearance: ___________________________________________

4. Yes No Sometimes Reluctance or refusal to go somewhere because of fear of separation.

Time / period of symptom appearance: ___________________________________________

5. Yes No Sometimes Excessive fear or reluctance to be along, without loved ones at home, or without important adults in other places.

Time / period of symptom appearance: ___________________________________________

6. Yes No Sometimes Reluctance or refusal to go to sleep without being near a loved one or to sleep away from home.

Time / period of symptom appearance: ___________________________________________

7. Yes No Sometimes Recurring nightmares about separation.

Time / period of symptom appearance: ___________________________________________

8. Yes No Sometimes Complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation occurs or is anticipated.

Time / period of symptom appearance: ___________________________________________

Notes: ______________________________________________________________

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Signature: X ____________________________________________ Date: ___/___/___

Parent / Legal Guardian Signature: X________________________________ Date: ____/____/____

## SYMPTOMS OF A PANIC ATTACK:

1. Yes No Sometimes Sudden fear or terror and a sense that a catastrophe is imminent
Time / period of symptom appearance: ______________________________________________

2. Yes No Sometimes Shortness of breath ___, sweating ___, palpitations ___, chest pain ___ and a smothering sensation ___
Time / period of symptom appearance: ______________________________________________

3. Yes No Sometimes Fear of going crazy ___ or being out of control ___ (often triggered by a particular situation, such as riding in an elevator, but may also occur spontaneously)
Time / period of symptom appearance: ______________________________________________

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## SYMPTOMS OF PANIC DISORDER:

1. Yes No Sometimes Persistent worry about having another panic attack ___ or altering the behavior to avoid having more attacks ___.
Time / period of symptom appearance: ______________________________________________

2. Yes No Sometimes Panic attacks not tied to a particular situation; can occur unexpectedly.
Time / period of symptom appearance: ______________________________________________

3. Yes No Sometimes Sudden fear or terror and a sense that catastrophe is imminent.
Time / period of symptom appearance: ______________________________________________

4. Yes No Sometimes Chest pains ___, shortness of breath ___, sweating ___, palpitations ___, and a smothering sensation ___.
Time / period of symptom appearance: ______________________________________________

5. Yes No Sometimes Fear of going crazy ___ or being out of control ___
Time / period of symptom appearance: ______________________________________________

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Signature: X ______________________________________________ Date: ___/___/___

Parent / Legal Guardian Signature: X______________________________________________ Date: ____/____/____

## SYMPTOMS OF SPECIFIC PHOBIA:

1. Yes No Sometimes Extreme fear of animals ___, objects ___, or situations ___ that pose no significant threat.
Time / period of symptom appearance: ______________________________

2. Yes No Sometimes Encountering the particular animal ___, object ___, or situation ___ produces anxiety immediately.
Time / period of symptom appearance: ______________________________

3. Yes No Sometimes Exposure may trigger a panic attack, which is marked by shortness of breath, sweating, palpitations, chest pain, or a smothering sensation.
Time / period of symptom appearance: ______________________________

4. Yes No Sometimes Altering behavior to avoid the fear – provoking object or situation.
Time / period of symptom appearance: ______________________________

## LIST OF PHOBIAS:

1. Yes No Fear of heights Acrophobia
Time / period of symptom appearance: ______________________________

2. Yes No Fear of being in a public place Agoraphobia
Time / period of symptom appearance: ______________________________

3. Yes No Fear of cats Ailurophobia
Time / period of symptom appearance: ______________________________

4. Yes No Fear of men Androphobia
Time / period of symptom appearance: ______________________________

5. Yes No Fear of human companionship Anthropophobia
Time / period of symptom appearance: ______________________________

6. Yes No Fear of spiders Arachnophobia
Time / period of symptom appearance: ______________________________

7. Yes No Fear of deep places Bathophobia
Time / period of symptom appearance: ______________________________

8. Yes No Fear of closed places Claustrophobia
Time / period of symptom appearance: ______________________________

9. Yes No Fear of dogs Cynophobia
Time / period of symptom appearance: ______________________________

10. Yes No Fear of insects Entomophobia
Time / period of symptom appearance: ______________________________

11. Yes No Fear of blushing Ereuthophobia
Time / period of symptom appearance: ______________________________

12. Yes No Fear of marriage Gamophobia
Time / period of symptom appearance: ______________________________

13. Yes No Fear of crossing a bridge Gephyrophobia
Time / period of symptom appearance: ____________________

14. Yes No Fear of seeing a naked person Gymnophobia
Time / period of symptom appearance: ____________________

15. Yes No Fear of women Gynephobia
Time / period of symptom appearance: ____________________

16. Yes No Fear of pleasure Hedonophobia
Time / period of symptom appearance: ____________________

17. Yes No Fear of responsibility Hypengyophobia
Time / period of symptom appearance: ____________________

18. Yes No Fear of sleep Hypnophobia
Time / period of symptom appearance: ____________________

19. Yes No Fear of fish Ichthyophobia
Time / period of symptom appearance: ____________________

20. Yes No Fear of dirt Mysophobia
Time / period of symptom appearance: ____________________

21. Yes No Fear of returning home Nostophobia
Time / period of symptom appearance: ____________________

22. Yes No Fear of night or darkness Nyctophobia
Time / period of symptom appearance: ____________________

23. Yes No Fear of snakes Ophidiophobia
Time / period of symptom appearance: ____________________

24. Yes No Fear of disease Pathophobia
Time / period of symptom appearance: ____________________

25. Yes No Fear of children or dolls Pediophobia
Time / period of symptom appearance: ____________________

26. Yes No Fear of phobias Phobophobia
Time / period of symptom appearance: ____________________

27. Yes No Fear of the cold Psychrophobia
Time / period of symptom appearance: ____________________

28. Yes No Fear of being stared at Scopophobia
Time / period of symptom appearance: ____________________

29. Yes No Fear of mirrors Spectrophobia
Time / period of symptom appearance: ____________________

30. Yes No Fear of childbirth Tocophobia
Time / period of symptom appearance: ____________________

31. Yes No Fear of God Theophobia
Time / period of symptom appearance: ____________________

32. Yes No Fear of the number 13 Triskaidekaphobia

Time / period of symptom appearance: ______________________________________________

33. Yes No Fear of animals Zoophobia

Time / period of symptom appearance: ______________________________________________

NOTES:____________________________________________________________________

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## SYMPTOMS OF SOCIAL PHOBIA:

1. Yes No Sometimes Extreme Uneasiness, self – consciousness, and fear of embarrassment in ordinary social situations.

2. Yes No Sometimes Avoidance of parties and social gatherings.

3. Yes No Sometimes Attending social gatherings may trigger a panic attack, which causes shortness of breath___, sweating___, palpitations___, chest pain___, or a smothering sensation___.

Note: Social Phobia is twice as common among women as it is among men.
Rarely starts after 25 years of age.

*If there are 3 or more yes of theses questions then the individual has social phobia.*

## SIGNS OF SOCIAL PHOBIA:

1. Yes No Sometimes Are you afraid you'll embarrass yourself if you have to give a talk or attend a social gathering with people you don't know well?

2. Yes No Sometimes Do you sometimes panic in unfamiliar social situations?

3. Yes No Sometimes Do you know that your fear of social situations is unreasonable or excessive?

4. Yes No Sometimes Do you avoid social situations whenever possible?

5. Yes No Sometimes When you can't avoid social situations, do they cause significant distress or anxiety?

6. Yes No Sometimes Does your distress or fear of social gatherings interfere significantly with your work, relationship with friends and family, or normal routines?

Signature: X ______________________________________Date: ___/___/___

Parent / Legal Guardian Signature: X_______________________________ Date: ____/____/____

## SYMPTOMS OF OBSESSIVE – COMPULSIVE DISORDER

1. Yes No Sometimes Persistent, involuntary thoughts, worries, or urges.

2. Yes No Sometimes Frequent repetition of specific rituals, such as organizing items, washing hands, or checking to make sure that the oven is off.

3. Yes No Sometimes Significant distress due to repetitive thoughts or actions, possibly impairing the ability to concentrate or function normally.

Note: Estimated to be present in 1 in 50 adults and 1 in 200 children.

## SYMPTOMS OF POST-TRAUMATIC STRESS DISORDER

1. Yes No Sometimes Recurring flashbacks, dreams, or instructive thoughts about a traumatic event.

2. Yes No Sometimes Withdrawal from people and certain situations.

3. Yes No Sometimes Avoiding reminders of the event.

4. Yes No Sometimes Difficulty sleeping.

5. Yes No Sometimes Being easily startled.

## SIGNS OF POST-TRAUMATIC STRESS DISORDER

1. Yes No Sometimes Have you witnessed or experienced a traumatic, life-threatening event in the last several months?

2. Yes No Sometimes Did this experience make you feel intensely afraid, horrified, or helpless?

3. Yes No Sometimes Do you have trouble getting the event out of your mind? Do you keep thinking about it during the day, dreaming about it having flashbacks, or experiencing intense psychological distress when you're reminded of it?

4. Yes No Sometimes Do you go out of your way to avoid activities, people, or thoughts that remind you of the event?

5. Yes No Sometimes Do you have more trouble falling asleep or concentrating than you did before the event?

6. Yes No Sometimes Do you startle more easily and feel more irritable or angry than you did before the event?

7. Yes No Sometimes Have your symptoms lasted for more that 1 month?

8. Yes No Sometimes Is your distress making it hard for you to work or function normally?

If there are 4 or more yes than it is a positive result for the presence of Post – Traumatic Stress Disorder.

Signature: X ____________________________________________ Date: ___/___/___

Parent / Legal Guardian Signature: X________________________________________ Date: ____/____/____

## GENERALIZED ANXIETY DISORDER

1. Yes No Do you worry a lot about all sorts of events or activities (as opposed to specific things like flying, becoming sick, or being embarrassed in public)?
2. Yes No Have you been worrying nearly every day for at least 6 months?
3. Yes No Do you usually have at least three of the symptoms: __ restlessness __ fatigue __difficulty concentrating __ irritability __ muscle tension __ trouble sleeping?
4. Yes No Do you have trouble controlling your worries?
5. Yes No Do you symptoms cause you considerate distress?
6. Yes No Are you sure your symptoms can't be explained by the following factors: __ an illness __ a medication __ other substance you are taking (caffeine, recreational drugs, etc.) or a traumatic experience?

## SYMPTOMS OF GENERALIZED ANXIETY DISORDER

1. Yes No Persistent, excessive worry about several different things for at least 6 months
2. Yes No __ Fatigue, __ difficulty sleeping, __ restlessness /agitation
3. Yes No Trouble concentrating
4. Yes No Irritability
5. Yes No Muscle tension
6. Yes No __ Feeling tense or __ on the edge

Note:______________________________________________________________________
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Signature: X ____________________________________________Date: ___/___/___

Parent / Legal Guardian Signature: X________________________________ Date: ____/____/____