

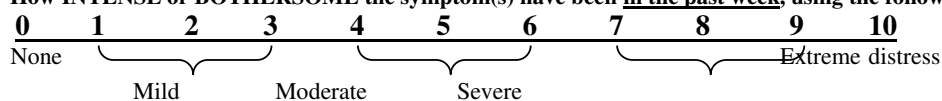
## Appendix

**ANXIETY SYMPTOMS QUESTIONNAIRE (ASQ)**

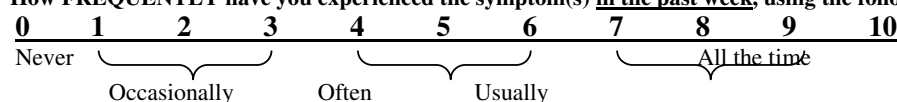
Please read each item and **fill each box with the number** in the scales below that best describes your experience regarding the Intensity(A) and Frequency (B) of these symptoms:

**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:

**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:



	<b>A</b>	<b>B</b>
<b>IN THE PAST WEEK:</b>	<b>INTENSITY (0 to 10)</b>	<b>FREQUENCY (0 to 10)</b>
1. Anxiety		
2. Nervousness		
3. Worrying		
4. Irritability		
5. Muscle Tension or Tightness		
6. Trouble Relaxing		
7. Trouble Falling or Staying Asleep <i>(Rate the most troublesome symptom)</i>		
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 <i>(Rate the most troublesome symptom)</i>		
12. Stomach Upset, Nausea, Constipation, Diarrhea, or Irritable Bowels <i>(Rate the most troublesome symptom)</i>		
13. Dizziness, Lightheadedness, Headaches, Trembling or Shakiness <i>(Rate the most troublesome symptom)</i>		
14. Numbness, Tingling, Excessive Sweating, Flushing or Frequent Urination <i>(Rate the most troublesome symptom)</i>		
15. Feeling Restless, Keyed Up, or On Edge		
16. Anticipating or Fearing Something Bad Might Happen		
17. Trouble Functioning at Home, Work, or Socially <i>Due to Anxiety (Rate the most troublesome symptom)</i>		

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