Burns Anxiety Inventory*

Name: _____ Date of Test:_____

DOB: _____

INSTRUCTIONS: **Mark the appropriate box with an X to answer each question.** **Please be honest and be sure to answer all questions on the page.** **Indicate how much each of the following symptoms has been bothering you in the past several days.**		**0- Not at all**	**1- Somewhat**	**2- Moderately**	**3- A lot**
CATEGORY I: ANXIOUS FEELINGS					
1	Anxiety, nervousness, worry or fear				
2	Feeling things around you are strange or foggy				
3	Feeling detached from all or part of your body				
4	Sudden unexpected panic spells				
5	Apprehension or a sense of impending doom				
6	Feeling tense, stress, “uptight” or on edge				
CATEGORY II: ANXIOUS THOUGHTS					
7	Difficulty concentrating				
8	Racing thoughts				
9	Frightening fantasies or daydreams				
10	Feeling on the verge of losing control				
11	Fears of cracking up or going crazy				
12	Fears of fainting or passing out				
13	Fears of illnesses, heart attacks, or dying				
14	Fears of looking foolish in front of others				
15	Fears of being alone, isolated or abandoned				
16	Fears of criticism or disapproval				
17	Fears that something terrible will happen				
CATEGORY II: PHYSICAL SYMPTOMS					
18	Skipping, racing or pounding of the heart				
19	Pain, pressure or tightness of the chest				
20	Tingling or numbness in the toes or fingers				
21	Butterflies or discomfort in the stomach				
22	Constipation or diarrhea				
23	Restlessness or jumpiness				
24	Tight, tense muscles				
25	Sweating not brought on by heat				
26	A lump in the throat				
27	Trembling or shaking				
28	Rubbery or “jelly” legs				
29	Feeling dizzy, lightheaded, or off balance				
30	Choking or smothering sensations or difficulty breathing				
31	Headaches or pains in the neck or back				
32	Hot flashes or cold chills				
33	Feeling tired, weak, or easily exhausted				

Office Use Only:
Score:_____
Test #: _____