Worry Checklist

First Name: _____ Date: _____

Please answer each question below as honestly as you can, and if you would like to explain any item, please circle it and make a note on the back.

	Is this true?	Does this distress you? 1 = not at all / 5 = very much
1. I worry a lot about things.	☐ Yes ☐ No	1 2 3 4 5
2. My worrying sometimes feels unreasonable or excessive to me or to other people.	☐ Yes ☐ No	1 2 3 4 5
3. I worry about events and activities, e.g., work, school, health, bad things happening, going out.	☐ Yes ☐ No	1 2 3 4 5
4. I find it difficult to control my worrying.	☐ Yes ☐ No	1 2 3 4 5
5. I feel restless, keyed up, or on edge.	☐ Yes ☐ No	1 2 3 4 5
6. I am easily tired.	☐ Yes ☐ No	1 2 3 4 5
7. I have problems concentrating.	☐ Yes ☐ No	1 2 3 4 5
8. I am irritable more often than I would like.	☐ Yes ☐ No	1 2 3 4 5
9. I have muscle tension that is not related to working out or other physical activity.	☐ Yes ☐ No	1 2 3 4 5
10. It takes me more than a half hour to fall asleep.	☐ Yes ☐ No	1 2 3 4 5
11. I wake up during the night and find my mind is very active.	☐ Yes ☐ No	1 2 3 4 5
12. I have trouble going back to sleep if I wake up during the night.	☐ Yes ☐ No	1 2 3 4 5
13. I don't feel rested when I wake up in the morning.	☐ Yes ☐ No	1 2 3 4 5
14. My sleep is restless and unsatisfying.	☐ Yes ☐ No	1 2 3 4 5
15. The way I worry about things can get in the way of my daily life or normal activities.	☐ Yes ☐ No	1 2 3 4 5
16. I have had times when I was short of breath, had heart palpitations, or felt shaky and could not explain why.	☐ Yes ☐ No	1 2 3 4 5
17. I have had times when I was afraid I would "lose control" or "go crazy."	☐ Yes ☐ No	1 2 3 4 5
18. I have avoided social situations because of fear or worry.	☐ Yes ☐ No	1 2 3 4 5
19. I have had fears of certain objects, e.g., animals or knives.	☐ Yes ☐ No	1 2 3 4 5
20. I have been afraid of places or situations from which I would not be able to escape if I needed to.	☐ Yes ☐ No	1 2 3 4 5
21. The idea of leaving the house has frightened me.	☐ Yes ☐ No	1 2 3 4 5
22. I have had disturbing thoughts or images in my head that I could not make go away.	☐ Yes ☐ No	1 2 3 4 5
23. I have had times when I needed to do things over and over, e.g., checking doors or turning off appliances.	☐ Yes ☐ No	1 2 3 4 5
24. I have had upsetting thoughts, feelings, sensations, or images about past events.	☐ Yes ☐ No	1 2 3 4 5