Hamilton Anxiety Scale

Name:		Date:	
DOB:	Height:	Weight:	
Health Care Provider:		Phone:	

Questions

Put a check mark in the box that BEST describes how you have felt in the last 6 months

Symptoms	Not Present	Mild	Moderate	Severe	Very Severe
Anxiety Worry, irritability, fearful anticipation					
Tension Restlessness, stress, inability to relax					
Fear Irrational phobia, excessive worry					
Insomnia Fatigue, inability to sleep, nightmares, night terrors					
Intellectual Symptoms Poor concentration, memory impairment					
Depressed Mood Decreased interest in activities, diurnal swing, early waking					
Muscular Symptoms Aches and pains, stiffness, twitching, teeth grinding					
Sensory Symptoms Tinnitus, blurred vision, hot/cold flushes, weakness					
Cardiovascular Symptoms Tachycardia, palpitations, chest pain, fainting, throbbing					
Respiratory Symptoms Chest pressure/constrictions, choking, sighing, dyspnea					
Gastrointestinal Symptoms Swallowing difficulties, abdominal pain, nausea, weight loss					
Genitourinary Symptoms Frequency/urgency of micturition, amenorrhea, impotence					
Autonomic Symptoms Dry mouth, flushing, pallor, sweating, giddiness, headache					
Behavior at Interview Fidgeting, restlessness, tremors, sighing, pallor, straining					