BAI Patient Self Evaluation

Name: _____ Date: _____

Instructions: Indicate how much you have been bothered by each symptom during the past week, including today, by circling the number in the column that most closely corresponds to how you've been feeling

	Not At All	**Mildly** It did not bother me much	**Moderately** It was very unpleasant but I could stand it	**Severely** I could barley stand it
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to Relax	0	1	2	3
Fear of the worst happening	0	1	2	3
Feeling dizzy or lightheaded	0	1	2	3
Heart pounding or racing	0	1	2	3
Unsteady	0	1	2	3
Terrified	0	1	2	3
Nervous	0	1	2	3
Feelings of Choking	0	1	2	3
Hands Trembling	0	1	2	3
Shaky	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion or discomfort In abdomen	0	1	2	3
Faint	0	1	2	3
Face Flushed	0	1	2	3
Sweating (not due to heat)	0	1	2	3

Total Score _____