Anxiety Screening Test

This information is based predominantly on the symptoms of *anxiety disorder* listed in the DSM IV.

Please answer each question to the best of your ability.

1. Do you worry about things, such as work or school, more days than not?
   € yes € no
2. Do you find it difficult to stop thoughts related to worrying?
   € yes € no
3. Do you often feel restless or on edge even when nothing is going on around you to cause these feelings?
   € yes € no
4. Is it hard for you to concentrate on specific tasks o do you often notice your mind just 'going blank'?
   € yes € no
5. Do you often feel irritable or tense even when nothing is going on which would justify this feeling?
   € yes € no
6. Is it difficult for you to fall asleep due to too many thoughts in your head?
   € yes € no
7. Do you notice you muscles getting tense frequently of feel tension in the muscles for your lower back, neck, or eyes?
   € yes € no
8. Do you find it difficult to sit still without having to fiddle with something, doodle, or make other repetitious movements?
   € yes € no
9. Have you noticed periods during the day when you have symptoms such as heart palpitations, sweaty palms, or shallow breathing?
   € yes € no
10. Do friends o family members tell you that you are too high strung, worry too much about little things, or need to 'chill'?
    € yes € no

If you answered "Yes" to 1-4 questions you might have mild anxiety.
If you answered "Yes" to 5-10 questions you might have major anxiety.

Contact PCS at 414-453-7306

Please bring with you the completed the ***Biographical Questionnaire*** to your first visit to PCS.