BELLI ACRES
PEDIATRICS

Patient Name_____ **Date**_____

A.S.A.Y.A.

Anxiety Screen in Adolescents and Young Adults-Self Test

Are you troubled by:

1.
Repeated, unexpected "attacks" during which you suddenly are overcome by intense fear or discomfort for no apparent reason, or the fear of having another panic attack?
Yes No

2.
Persistent, inappropriate thoughts, impulses or images that you can't get out of your mind (such as a preoccupation with getting dirty or worry about the order of things)?
Yes No

3.
Distinct and ongoing fear of social situations involving unfamiliar people?
Yes No

4.
Excessive worrying about a number of events or activities?
Yes No

5.
Fear of places or situations where getting help or escape might be difficult, such as in a crowd or an an elevator?
Yes No

6.
Shortness of breath or racing heart for no apparent reason?
Yes No

7.
Persistent and unreasonable fear of an object or situation, such as flying, heights, animals, blood, etc.?
Yes No

8.
Being unable to travel alone, without a companion?
Yes No
9.
Spending too much time each day doing things over and over again (for example, hand washing, checking things, or counting)?
Yes No

More days than not, do you:
10.
Feel restless?
Yes No

11.
Feel easily fatigued or distracted?
Yes No

12.
Experience muscle tension or problems sleeping?
Yes No

More days than not, do you feel:

13.
Sad or depressed?
Yes No

14.
Disinterested in life?
Yes No

15.
Worthless or guilty?
Yes No

16.
Have you experienced changes in sleeping or eating habits?
Yes No

17.
Do you relive a traumatic event through thoughts, games, distressing dreams, or flashbacks?
Yes No

18.
Does your anxiety interfere with your daily life?
Yes No