Brain Wellness Center

San Ramon office: 2410 San Ramon Valley Blvd, Suite #140 San Ramon CA 94583 Phone: (925)837-1100
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Fax: (925)837-1112 Website: www.brain123.com

BURN'S ANXIETY INVENTORY

NAME: ____**DATE:**_____________

Instructions: Circle the space that best describes how you have been feeling the past week.

Category I: Anxious Feelings	Not at all	Somewhat	Moderately	A lot
1.Anxiety, nervousness, worry or fear	0	1	2	3
2.Feeling that things around you are strange, unreal or foggy	0	1	2	3
3.Feeling detached from all or part of your body	0	1	2	3
4. Sudden, unexpected panic spells	0	1	2	3
5. Apprehension or a sense of impending doom	0	1	2	3
6. Feeling tense, stressed, "uptight" or on edge	0	1	2	3
Category II: Anxious Thoughts				
7. Difficulty Concentrating	0	1	2	3
8. Racing thoughts or having your mind jump from one thing to next	0	1	2	3
9. Frightening fantasies or daydreams	0	1	2	3
10. Feeling that you're on the verge of losing control	0	1	2	3
11. Fears of cracking up or going crazy	0	1	2	3
12. Fears of fainting or passing out	0	1	2	3
13. Fears of physical illness or heart attacks or dying	0	1	2	3
14. Concerns about looking foolish or inadequate in front of others	0	1	2	3
15. Fears of being alone, isolated or abandoned	0	1	2	3
16. Fears of criticism or disapproval	0	1	2	3
17. Fears that something terrible is about to happen	0	1	2	3
Category III: Physical Symptoms				
18. Skipping or racing or pounding of the heart	0	1	2	3
19. Pain, pressure or tightness in the chest	0	1	2	3
20. Tingling or numbness in the toes or fingers	0	1	2	3
21. Butterflies or discomfort in the stomach	0	1	2	3
22. Constipation or diarrhea	0	1	2	3
23. Restlessness or jumpiness	0	1	2	3
24. Tight, tense muscles	0	1	2	3
25. Sweating not brought on by heat	0	1	2	3
26. A lump in the throat	0	1	2	3
27. Trembling or shaking	0	1	2	3
28. Rubbery or "jelly" legs	0	1	2	3
29. Feeling dizzy, light-headed or off balance	0	1	2	3
30. Choking or smothering sensations or difficulty breathing	0	1	2	3
31. Headaches or pains in the neck or back	0	1	2	3
32. Hot flashes or cold chills	0	1	2	3
33. Feeling tired, weak or easily exhausted	0	1	2	3
Add up total:				
Total:				

0-4 Minimal or No Anxiety; 5-10 Borderline; 11-20 Mild; 21-30 Moderate; 31-50 Severe; 51-99 Extreme Anxiety or Panic

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BURN'S DEPRESSION INVENTORY

Instructions: Circle the space that best describes how you have been feeling the past week.	None	Somewhat	Moderately	A Lot
SYMPTOM LIST				
Sadness: Do you feel sad or down in the dumps?	0	1	2	3
Discouragement: Does your future look hopeless?	0	1	2	3
Low Self-Esteem: Do you feel worthless?	0	1	2	3
Inferiority: Do you feel inadequate or inferior to others?	0	1	2	3
Guilt: Do you get self-critical and blame yourself?	0	1	2	3
Indecisiveness: Is it hard to make decisions?	0	1	2	3
Irritability: Do you frequently feel angry or resentful?	0	1	2	3
Loss of interest in life: Have you lost interest in your career, hobbies, family and friends?	0	1	2	3
Loss of motivation: Do you have to push yourself to do things?	0	1	2	3
Poor Self-Image: Do you feel old and unattractive	0	1	2	3
Appetite Changes: Have you lost your appetite? Do you overeat or binge compulsively?	0	1	2	3
Sleep Changes: Is it hard to get at good night's sleep? Are you excessively tired and sleeping too much?	0	1	2	3
Loss of Libido: Have you lost your interest in sex?	0	1	2	3
Concerns about Health: Do you worry excessively about your health?	0	1	2	3
Suicidal Impulses? Do you have thoughts that life is not worth living or think you'd be better off dead?	0	1	2	3
Add up your total and record it here:	0			
Total:				

0-4 Minimal or No Depression; 5-10 Borderline; 11-20 Mild; 21-30 Moderate; 31-45 Severe

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NAME:____ **DATE:**______________

PATIENT HEALTH QUESTIONARIE (PHQ-9)

Instructions: Circle the space that best describes how you have been feeling the past week.

	Not at all	*Once in a while*	*More than half the days*	*Nearly every day*
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3
Add columns:		+	+	
			Total:	

10. If you checked off any problems, how difficult at all have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE

Instructions: Circle the space that best describes how you have been feeling the past week.

	Not at all	Once in a while	More than half the days	Nearly Every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add score for each column				
Total				

If you checked off any problems, how difficult at all have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult