Saint Louis
BEHAVIORAL
MEDICINE
Institute

ASI-IV

GENERAL INSTRUCTIONS: This form asks about common symptoms or problems that you may have experienced. Unless otherwise specified, the questions refer to what you are experiencing NOW, not in the past. It is important that you read each questions very carefully and answer as honestly as possible. Please do not hold back telling us information that could be important. Your answers will be kept strictly confidential.

1. Name: _____ 2. Date: _____

3. Age: _____ 4. Date of Birth: _____

5. Sex: _____Female ____Male

6. Ethnic background: ____ African American ____ Asian

____ Hispanic ____ Native American

____ White ____ Other

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SECTION I

A panic attack is a very sudden (reaches its peak in less than 10 minutes) and intense rush of fear or discomfort and a feeling that something terrible is about to happen like going crazy, dying, fainting, or losing control. Please answer the following questions about panic.

1. Based upon this description, have you ever had a panic attack? ____ YES ____ NO
   (if "NO", go to #6 in this section.)

2. Check each of the following symptoms you have experienced when having a panic attack:

   ___ Difficulty breathing or smothering sensation
   ___ Rapid or irregular heart beats or pounding heart
   ___ Chest pain or discomfort
   ___ Dizziness or feeling unsteady, faint, light-headed
   ___ A sense of unreality, things seem removed or you feel detached from yourself
   ___ Hot or cold flashes
   ___ Sweating
   ___ Choking sensation
   ___ Trembling or shaking
   ___ Nausea or stomach ache
   ___ Numbness or tingling sensations
   ___ Other (indicate): _____

3. Have you had at least two panic attacks that were unexpected or seemed to come out of the blue?
   ____ YES ____ NO

4. Check any of the experiences below that you have had for at least one month following a panic attack:
   ___ Concern about having another panic attack.

   ___ Worry about the implications or consequences of the panic attacks (e.g., losing control, heart attack, "going crazy")

   ___ A significant change in your behavior (e.g., going to the emergency room, extra visits to the doctor, asking others to accompany you places) because of the panic attacks.

5. Do you currently avoid or dread leaving your home, driving, crowds, traveling, being alone or any other places or situations in which you feel trapped or unable to get help from others specifically because you are afraid you might experience a panic attack?
   ____ YES ____NO

SECTION I (continued)

6. Check any of the symptoms listed below that you currently FEAR OR WORRY about experiencing, even if they did not occur with a panic attack. (These are symptoms that come on suddenly but can happen by themselves, without a panic attack.)

___ Severe headache
___ Losing control of your bladder
___ Losing control of your bowels
___ Other (specify): _____

___ Dizziness
___ Chest pain or discomfort
___ Vomiting

7. If you checked any symptoms in #6:

   a. Do you currently avoid or dread leaving home, driving, crowds, traveling, being alone or any other places or situations in which you feel trapped or unable to get help from others because you are afraid you might experience that symptom? ___ YES ___NO

   b. Have other people said or do you believe that your concern about this symptom or your reaction to it is excessive compared to other people who experience that symptom? ___ YES ___NO

8. If you answered "YES" to any questions or checked any items in Section I (items 1-7), does this problems SIGNIFICANTLY INTERFERE with your life (work, school, social activities, relationships, etc.) OR cause you A LOT OF DISTRESS? ___ YES ___NO

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SECTION II

1. Place a check mark beside any behaviors listed below that, compared to other people, you spend a lot of time doing.

___ Washing or cleaning yourself or your possessions
___ Repeatedly checking things (e.g., light switches, water faucets, pilot light, bumps in the road, etc.)
___ Counting objects
___ Collecting or hoarding things (i.e., won't throw things away)
___ Intentionally repeating behaviors or thoughts over and over again in a particular way, or for a "special" number of times
___ Straightening or making things neat or perfect
___ Concentrating on certain "good" or "safe" things to get rid of "bad" thoughts, numbers, images or designs that appear in your mind

2. If you engage in any of the behaviors listed above in #1, check any concerns below you have that make it difficult for you to resist or stop the behavior.

___ Concern about dirt, germs, sweat, or another form of personal "contamination"
___ Concern that you have forgotten something or done something wrong that would cause harm to you or to others
___ Concern that things feel or seem like they're "wrong," "not right," "sinful," or "not perfect"
___ Concern that you will feel so bad or nervous that you will lose control of your behavior or become overwhelmed, or that the bad feeling will never go away

3. Do you experience very upsetting thoughts or impulses that seem to happen against your will AND that involve unacceptable sexual or violent acts OR that are against your moral or religious beliefs?
(check one) ____ YES ___NO

4. If you checked any item or answered "yes" to any questions on this page:

a. Does this problem take up at least one hour of your day on average? ____ YES ___ NO

b. Does this problem SIGNIFICANTLY INTERFERE with your life (work, school, social activities, relationships, etc.) OR cause you A LOT OF DISTRESS?
___ YES ___NO

c. Are your concerns simply excessive worries about common, real life problems?
___ YES ___NO

SECTION III

1 Check any of the social or performance situations listed below in which you would feel nervous or fearful because you might do something embarrassing or be criticized.

___ Speaking or performing in front of others
___ Using public restrooms
___ Eating in restaurants or other public settings
___ Writing in front of others (e.g., signing checks or credit card receipts)
___ Attending parties or other social functions
___ Going on dates
___ Other situations in which you are (or could become) the center of attention:
_____

2 If you checked any of the situations above:

a. Do you avoid, dread or uncomfortably endure any of the situations specifically because of a concern about being embarrassed or criticized?
____ YES ___NO

b. Does being in any of these situations provoke extreme anxiety (such as a panic attack like those described in Section I)? ___ YES ___NO

c. Does this problem SIGNIFICANTLY INTERFERE with your life (work, school, social activities, relationships, etc.) OR cause you A LOT OF DISTRESS? ___ YES ___ NO

c. Do you believe your fear in this situation is unreasonable or excessive compared to how most other people feel? ____YES ___ NO

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SECTION IV

1. Check any of the following things you fear:

   ___ A particular type of animal or insect (e.g., spider, snake, dog, mouse, etc.)

   ___ Natural disaster (e.g., storms, earthquakes)

   ___The sight of blood or injury

   ___ Heights

   ___ Enclosed spaces

   ___ Flying

   ___Traveling by car, bus, or train

   ___ Other (please list):_____

   _____

2. If you checked any of the items in #1 above:

   a. Do you avoid or dread coming into contact with any of the thing(s) or situation(s) you checked, or endure it with discomfort when you do have contact? ___YES ___ NO

   b. Does the fear currently SIGNIFICANTLY INTERFERE with your life (work, school, social activities, relationships, etc.) OR cause you A LOT OF DISTRESS? ___ YES ___NO

   c. Do you believe your fear in this situation in unreasonable or excessive compared to how most other people feel? ____YES ____NO

   d. Is your fear in this situation due ONLY to concern about having a panic attack or being embarrassed or criticized? ____ YES ____NO

   e. Does contact with this thing(s) or situation(s) almost always cause anxiety or discomfort? ____YES ____NO

SECTION V

Below are some questions about "worry." Worry is thinking about problems or anticipating something bad happening in the future and the nervous or anxious feeling you experience when you do this.

1. Over the past 6 months, have you spent more days worrying than not worrying?
___YES ____ NO

2. Has it been difficult for you to control the worry (either what you're worrying about or the time you spend worrying)? ____YES ____NO

3. Have other people said or do you believe that you worry too much or that your worries are often unreasonable or excessive? ____ YES ____ NO

4. Check each theme below that you worry about:

___ Family or relationships
___ Money or finances
___ Crime, violence or accidents
___ Health or illness
___ Work or school
___ Other (list) _____
_____

5. When you worry about the things you checked above in #4, do you worry for reasons other than concern about panic attacks, or being embarrassed or criticized? ____YES ____ NO

6. Check those symptoms below that occur while you worry:

___ Feeling restless, keyed up, or on edge
___ Being easily fatigued
___ Difficulty concentrating or your mind going blank
___ Irritability
___ Muscle tension (e.g., backache, headache, muscle aches)
___ Sleep problems (e.g., difficulty falling or staying asleep or restless, unsatisfying sleep)

7. Does the anxiety, worry, or physical symptoms SIGNIFICANTLY INTERFERE with your life (work, school, social activities, relationships, etc.) OR cause you A LOT OF DISTRESS?
____YES ____ NO

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SECTION VI

A "traumatic event" is an event that involves actual or threatened death or serious injury OR a serious threat to the physical well-being of yourself or others.

1. Have you ever experienced a traumatic event? ____YES ____ NO

2. Did you respond to the traumatic event with intense fear, helplessness, or horror?
____ YES ____ NO

3. If you answered "YES" to questions 1 and 2 above, please respond to the following:

   a. Do you repeatedly experience memories (including thoughts or images) of the event that interrupt your activities? ____ YES ____ NO

   b. Do you repeatedly experience distressing dreams or nightmares about the event?
   ____ YES ____ NO

   c. Do you experience a sense of reliving the experience or feeling or acting as if the event were recurring? ____ YES ____ NO

   d. Do you experience intense emotional distress if you are exposed to situations which resemble the event or the feelings you associate with the event? ____ YES ____ NO

   e. Do you experience intense physical symptoms if you are exposed to situations which resemble the event or the feelings you associate with the event? ____ YES ____ NO

4. Individuals who have experienced traumatic events can have a variety of responses and experiences. Please check below those responses you experience:

   ___ Avoiding thoughts, feelings or conversations associated with the event
   ___ Avoiding activities, places, or people that arouse memories of the event
   ___ Inability to recall some important aspect of the event
   ___ Decreased interest in or participation in previously enjoyed activities
   ___ Feeling detached or separate from others
   ___ Being unable to experience emotion (e.g., unable to have loving feelings)
   ___ Feeling like future events just will not happen

SECTION VI (continued)

5. Please indicate if you currently have any of the following symptoms which were not present before the traumatic event:

___ Difficulty falling or staying asleep
___ Irritability or outbursts of anger
___ Feeling constantly on the alert
___ Difficulty concentrating
___ Startle easily

6. Do the symptoms associated with the event SIGNIFICANTLY INTERFERE with your life (work, school, social activities, or relationships, etc.) OR cause you A LOT OF DISTRESS?

____ YES ____ NO

7. Please indicate how long these symptoms have lasted:

____ Less than 1 month ____ 1 month or more