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
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 ___ Dizziness
___ Losing control of your bladder ___ Chest pain or discomfort
___ Losing control of your bowels ___ Vomiting
___ Other (specify): __________________________

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
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
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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
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        ___ Health or illness
    ___ Money or finances             ___ Work or school
    ___ Crime, violence or accidents  ___ 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
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
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  ___ Difficulty concentrating
___ Irritability or outbursts of anger   ___ Startle easily
___ Feeling constantly on the alert

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