SFU SIMON FRASER UNIVERSITY
ENGAGING THE WORLD

Researcher's Initials

Participation Number **Date**

Please state your Age

Please state your Gender

Please answer the following questions as honestly as possible by ticking the box that best fits with your opinion.

	Not Present	Mild	Moderate	Severe	Very Severe
ANXIOUS MOOD (worries, irritability)	○	○	○	○	○
TENSION (startle, cry easily, restless, trembling)	○	○	○	○	○
FEARS (fear of the dark, fear of strangers, fear of being alone, fear of animal)	○	○	○	○	○
INSOMNIA (difficulty falling asleep or staying asleep, difficulty with nightmares)	○	○	○	○	○
INTELLECTUAL (poor concentration, memory impairment)	○	○	○	○	○
DEPRESSED MOOD (loss of interest, lack of pleasure in hobbies)	○	○	○	○	○

Please answer the following questions as honestly as possible by ticking the box that best fits with your opinion.

	Not Present	Mild	Moderate	Severe	Very Severe
SOMATIC (muscular pains and aches, twitching, stiffness)	○	○	○	○	○
SOMATIC (sensory, blurry vision, Tinnitus, hot & cold flashes)	○	○	○	○	○
CARDIOVASCULAR SYMPTOMS (palpitations, pain in chest, tainting feeling)	○	○	○	○	○
RESPIRATORY SYMPTOMS (pressure or constriction in chest, choking feelings, sighing)	○	○	○	○	○
GASTROINTESTINAL SYMPTOMS (difficulty in swallowing, wind abdominal pain, burning sensation,nausea)	○	○	○	○	○
GENITOURINARY SYMPTOMS (urinary frequency or urgency)	○	○	○	○	○
AUTONOMIC SYMPTOMS (dry mouth, flushing, tendency to sweat, tension)	○	○	○	○	○
BEHAVIOR AT INTERVIEW (fidgeting, restlessness, tremor of hands, strained face, signing)	○	○	○	○	○

Will you see your usual or regular doctor today?

- ○ Yes
- ○ No
- ○ Not sure

Thinking about the doctor you are about to see, please answer the following questions as honestly as possible by ticking the box that best fits with your opinion.

	Disagree	Neither agree or disagree	Slightly Agree	Mostly Agree	Totally Agree
I know this doctor very well	○	○	○	○	○
This doctor really knows how I feel about things	○	○	○	○	○
This doctor takes me seriously	○	○	○	○	○
This doctor accepts me the way I am	○	○	○	○	○
I feel totally relaxed with this doctor	○	○	○	○	○

In a few words, how would you describe the atmosphere of the waiting room at the clinic?

Is this your first time visiting this clinic?

- ○ Yes
- ○ No

If no, please indicate how often you visit this clinic.

- ○ Once a month
- ○ Every 2 weeks
- ○ Once a week

Do you take medication for anxiety? If so, please indicate the type of medication.

- ○ Yes
- ○ No

Please provide any additional feedback.