MISSION PSYCHIATRY

Anxiety Self-Assessment

Think about the past two weeks and select the response that best describes how often you have experienced each symptom.

Question	Not at all	Several days	More than half the days	Nearly every day
1. Have you felt nervous, anxious, worried, or on edge?				
2. Have you found it difficult to control or stop worrying?				
3. Have you worried excessively about different areas of your life, such as work, school, finances, health, or relationships?				
4. Have you felt restless, keyed up, or unable to relax?				
5. Have you experienced difficulty concentrating or found your mind going blank because of worry or anxiety?				
6. Have you been more irritable, impatient, or easily frustrated than usual?				
7. Have you experienced muscle tension, headaches, stomach discomfort, or other physical tension related to anxiety?				
8. Have you experienced changes in your sleep because of worry or anxiety?				
9. Have you avoided people, places, activities, or situations because they made you feel anxious or uncomfortable?				
10. Have your anxiety or worries made it harder to manage your work, school, relationships, or everyday responsibilities?				

Important Disclaimer: This self-assessment provided by Mission Psychiatry is intended for informational and educational purposes only. It is not a diagnostic test and does not diagnose anxiety or any other mental health condition. Your results are meant to serve as a helpful guide and starting point for discussion, not as an official diagnosis. Only a qualified healthcare professional can provide a diagnosis after a comprehensive evaluation.