

**MCCRACKEN COUNSELING AND ASSOCIATES**

**MCCA**

**ANXIETY CHECK LIST**

**Name:** \_\_\_\_\_

**CHECK ALL THAT MAY APPLY:**

- |   |                                |
|---|--------------------------------|
| _____ Excessive, ongoing worry and tension        | _____ Tiredness                |
| _____ Trouble falling or staying asleep           | _____ Trembling                |
| _____ Being easily startled                       | _____ Racing" heart            |
| _____ Feeling weak, faint, or dizziness           |                                |
| _____ Tingling or numbness in the hands/fingers   |                                |
| _____ Sense of terror, or impending doom or death |                                |
| _____ Feeling sweaty or having chills             |                                |
| _____ Chest pains                                 |                                |
| _____ Breathing difficulties                      |                                |
| _____ Feeling a loss of control                   |                                |
| _____ Restlessness/ feeling of being "edgy"       |                                |
| _____ Irritability                                |                                |
| _____ Muscle Tension                              | _____ Headaches                |
| _____ Sweating                                    | _____ Difficulty concentrating |
| _____ Nausea                                      |                                |
| _____ The need to go to the bathroom frequently   |                                |
| _____ Tiredness                                   |                                |

\_\_\_\_\_ **Trouble falling or staying asleep**

\_\_\_\_\_ **Trembling**

\_\_\_\_\_ **An unrealistic view of problems**

\_\_\_\_\_ **Being easily startled**

\_\_\_\_\_ **Racing" heart**

\_\_\_\_\_ **Feeling weak, faint, or dizzy**

\_\_\_\_\_ **Tingling or numbness in the hands/fingers**

\_\_\_\_\_ **Sense of terror, or impending doom or death**

\_\_\_\_\_ **Feeling sweaty or having chills**

\_\_\_\_\_ **Chest pains**

\_\_\_\_\_ **Breathing difficulties**

\_\_\_\_\_ **Feeling a loss of control**