



Name:	
Date:	

FEAR/ANXIETY ASSESSMENT

	Never					Always				
I struggle with worry daily.	1	2	3	4	5	6	7	8	9	10
I experience panic attacks.	1	2	3	4	5	6	7	8	9	10
My worry keeps me awake at night.	1	2	3	4	5	6	7	8	9	10
I have frequent stomach aches that appear to be connected with my anxiety.	1	2	3	4	5	6	7	8	9	10
I currently take medication for my anxiety.	1	2	3	4	5	6	7	8	9	10
I seek to find ways to trust God with areas outside my control.	1	2	3	4	5	6	7	8	9	10
I worry about my family.	1	2	3	4	5	6	7	8	9	10
I worry about my marriage.	1	2	3	4	5	6	7	8	9	10
I am afraid of dying.	1	2	3	4	5	6	7	8	9	10
I am afraid of God's perspective of me.	1	2	3	4	5	6	7	8	9	10
I experience a racing heart, chest pain, difficulty breathing, or lightheadedness as a result of my fear/anxiety.	1	2	3	4	5	6	7	8	9	10
My fears/anxiety is connected with a past traumatic event.	1	2	3	4	5	6	7	8	9	10
I worry about getting sick.	1	2	3	4	5	6	7	8	9	10
I am unable to relax.	1	2	3	4	5	6	7	8	9	10
I get depressed as a result of feeling out of control.	1	2	3	4	5	6	7	8	9	10
I am anxious or fearful about what people think about me.	1	2	3	4	5	6	7	8	9	10
I have difficulty concentrating because of my worry/fear.	1	2	3	4	5	6	7	8	9	10

I worry/fear if I will ever be happy with my life.	1	2	3	4	5	6	7	8	9	10
My work or school is affected by my fears/worries.	1	2	3	4	5	6	7	8	9	10

Short Answer:

What particular areas do you tend to stay away from due to fear or anxieties?

SAMPLE

How have you sought to deal with your frequent fear/anxiety?

SAMPLE

What makes it difficult to control your fears or anxieties?

SAMPLE

Is there anything that you believe would help you cope better with your fear or anxiety?

SAMPLE

Other Information you would like to share about your fears or anxieties.

SAMPLE