**SCREENING FOR**

**ANXIETY AND**

**ANXIETY-RELATED**

**PSYCHOLOGICAL**

**DISTURBANCES**

**Instructions: Please complete the following questionnaire.
Upon completion please mail to:
Mivie Health
PO Box 3339
Wayne, NJ 07470**

**Or email to:
miviehealth@aol.com**

 **Once received, you will be issued your $5.00 off coupon.**

**This is a compilation of screening tools from about 10 different sources in the psych and family practice literature.**

**From my literature review, there is no one “standard,” or agreed upon set of evaluation tools for anxiety and related disorders. In fact, the diagnosis of these disorders is highly subjective and difficult to quantify.**

**Therefore, rather than attempting to impose some arbitrary sort of classification system, it seems more logical to start with a broad range of evaluation tools, and then narrow it down, on a case by case basis.**

**As long as there is consistency in the approach, and the methods (i.e. examiner asks questions, multiple choice written, by subject, etc.), then we can create a stable “scoring system” to be used in each case, even if the questions are honed down to an easy to answer set, that most accurately reflects the patient-identified disturbances.**

**Then this can be used on successive evaluations, and the score on each will be compared to the first – and this, with or without the need to compare to other subjects, should form an adequate assessment of the efficacy, at least in a subjective sense, of any given, or proposed treatment modality or administered drug.**

**This compilation is divided into six sections:**

**Section Subject Questions**

**Section 1 General Anxiety Screening Questions 41**

**Section 2 Anxiety in children ages 4 through 17 32**

**Section 3 Child Social Anxiety Questions 15**

**Section 4 Narrative Practitioner Subjective Questions 14**

**Section 5 Basic PTS Screening 4**

**Section 6 General PTS Screening 18**

**Suggestions for use in clinical study**

Depending on how much time we want the subjects to spend on the questions, we should design, using the questions below, and any additional questions that we may wish to add, three basic formats, depending on the patient’s initial screening:

General Anxiety – Adult Use sections 1 and 4 (55 questions)

General Anxiety – Child Use sections 2, 3, and 4 (61 questions)

(with or without social component)

PTS or similar syndromes Use sections 1 and 6 (59 questions)

I suggest that we wait on looking at ADD, until we see some initial results, just looking at anxiety symptoms.

If we use the questions, based on a self-designated scale of 1 to 5, rather than just yes/no, we can then develop a “scoring” system that is standardized, such as the one below.

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The following table is developed for a set of 13 questions.

For any given set of questions with a 1 to 5 scale, add up the total of all the questions. Then, take this score, divide it by your total number of questions, then multiply that by 13.

Then, look up the T-score in the table below.

There can be some variation, but, in general a T-score of:

T-Score Indicates

Under 55 Minimal disturbance

Between 55 and 60 Mild disturbance

Between 61 and 70 Moderate Disturbance

Over 70 Severe disturbance

**T-Score Lookup Table**

Score T-Score SE

13 32.3 5.7

14 36.6 4.8

15 38.9 4.6

16 41.1 4.3

17 42.8 4.1

18 44.3 3.9

19 45.7 3.8

20 47 3.7

21 48.2 3.6

22 49.4 3.5

23 50.4 3.4

24 51.4 3.4

25 52.4 3.3

26 53.3 3.3

27 54.2 3.3

28 55.1 3.3

29 56 3.2

30 56.8 3.2

31 57.6 3.2

32 58.4 3.2

33 59.2 3.2

34 60 3.2

35 60.8 3.2

36 61.6 3.1

37 62.3 3.1

38 63.1 3.1

39 63.8 3.1

40 64.5 3.1

41 65.3 3.1

42 66 3.1

43 66.8 3.1

44 67.5 3.1

45 68.2 3.1

46 69 3.1

47 69.7 3.1

48 70.5 3.1

49 71.3 3.1

50 72 3.1

51 72.8 3.2

52 73.6 3.2

53 74.4 3.2

54 75.3 3.2

55 76.1 3.3

56 77 3.3

57 77.9 3.4

58 78.9 3.4

59 79.9 3.5

60 81 3.6

61 82.1 3.7

62 83.3 3.7

63 84.7 3.8

64 86.1 3.8

**Section 1 – General Anxiety Screening Questions**

Total 41 questions

Are you bothered by:

* Excessive worry, occurring more days than not, for a least six months
* Unreasonable worry about events or activities, such as work, school, or your health
* The inability to control the worry
* Restlessness, feeling keyed-up, or on edge
* Being easily tired
* Problems concentrating
* Irritability
* Muscle tension
* Trouble falling or staying asleep, or restless and unsatisfying sleep
* Your anxiety interfering with your daily life
* Have you experienced changes in sleeping or eating habits?

More days than not, do you feel:

* sad or depressed?
* disinterested in life?
* worthless or guilty?

During the last year, has the use of alcohol or drugs:

* resulted in your failure to fulfill responsibilities with work, school, or family?
* placed you in a dangerous situation, such as driving a car under the influence?
* gotten you arrested?
* continued despite causing problems for you or your loved ones?

Are you troubled by the following:

* An intense and persistent fear of a social situation in which people might judge you
* Fear that you will be humiliated by your actions
* Fear that people will notice you blushing, sweating, trembling, or showing other signs of anxiety
* Knowing that your fear is excessive or unreasonable

Does a feared situation cause you to:

* always feel anxious?
* experience a panic attack
* feel overcome by intense fear or discomfort
* feel any of these symptoms:

- Pounding heart

- Sweating

- Trembling or shaking

- Choking

- Chest pain

- nausea or abdominal discomfort

- "Jelly" legs

- Dizziness

- Feelings of unreality or being detached from yourself

- Fear of losing control or “going crazy”

- Fear of dying

- Numbness or tingling sensations

- Chills or hot flushes

Does a feared situation cause you to

* go to great lengths to avoid participating?
* have your symptoms interfere with your daily life?

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**Section 2 – For children ages 4 to 17**

Total 32 questions

**Part A - For parent – My child, over the past week:**

* He/she felt like something awful might happen.
* He/she felt nervous.
* He/she felt scared.
* He/she felt worried.
* He/she worried about what could happen to him/her.
* He/she worried when he/she went to bed at night.
* He/she got scared really easy.
* He/she was afraid of going to school.
* He/she worried when he/she was at home.
* He/she worried when he/she was away from home.

**Part B – For child - Over the past week:**

* I felt like something awful might happen.
* I felt nervous.
* I felt scared.
* I felt worried.
* I worried about what could happen to me.
* I worried when I went to bed at night.
* I got scared really easy.
* I was afraid of going to school.
* I worried when I was at home.
* I worried when I was away from home.
* I was worried I might die.
* I woke up scared during the night.
* It's been hard for me to relax.

**Part C - Additional somatic symptoms**

* Back pain
* Pain in arms, legs, or joints (knees, hips, etc.)
* Headaches
* Chest pain
* Dizziness
* Fainting spells
* Feeling heart pound or race
* Trouble sleeping
* Irregular bowels

**Section 3 – For Parent – Social Anxiety Screening Questions**

Total 15 questions

For parent – on child social anxiety

* Does your child have a distinct and ongoing fear of social situations involving unfamiliar people?
* Does your child worry excessively about a number of events or activities?
* Does your child experience shortness of breath or a racing heart for no apparent reason?
* Does your child experience age-appropriate social relationships with family members and other familiar people?
* Does your child often appear anxious when interacting with peers, or try to avoid them?
* Does your child have a persistent and unreasonable fear of an object or situation, such as flying, heights, or animals?
* When encountering the feared object or situation, does he react by freezing, clinging, or having a tantrum?
* Does your child worry excessively about her competence and quality of performance?
* Does your child cry, have tantrums, or refuse to leave a family member or other familiar person when necessary?
* Has your child experienced a decline in classroom performance, refused to go to school, or avoided age-appropriate social activities?
* Does your child spend at least one hour each day repeating things over again, such as hand washing, checking, arranging, or counting?
* Does your child have exaggerated and irrational fears of people, places, objects or situations that interfere with his or her social and academic life?
* Does your child experience a great number of nightmares, headaches, or stomachaches?
* Does your child repetitively use toys to re-enact scenes from a disturbing event?
* Does your child redo tasks because of excessive dissatisfaction with less-than-perfect performance?

**Section 4 – Practitioner Administered Subjective Narrative Questions**

Total 14 questions

Simple Narrative Screening of Systems

Simple Screening of affected systems – Can either by put into a written, or multiple choice format, or can be asked at interview, and responses, along with subject and interviewer’s comments written into clinical notes:

Anxious mood - Worries, anticipation of the worst, fearful anticipation, irritability.

Tension - Feelings of tension, fatigability, startle response, moved to tears easily,

trembling, feelings of restlessness, inability to relax.

Fears - Of dark, of strangers, of being left alone, of animals, of traffic, of crowds

Insomnia - Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking,

nightmares, night terrors.

Intellect - Difficulty in concentration, poor memory

Depressed mood - Loss of interest, lack of pleasure in hobbies, depression, early waking

Somatic - Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth,

unsteady voice, increased muscular tone.

Sensory - Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, prickling sensation.

Cardiac - Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feeling.

Respiratory - Pressure or constriction in chest, choking feelings, sighing, dyspnea.

GI - Difficulty in swallowing, abdominal pain, burning sensations, fullness, nausea,

vomiting, loose stools, weight loss, constipation.

GU - Frequency, urgency, amenorrhea, frigidity, decreased libido, impotence.

Autonomic - Dry mouth, flushing, pallor, tendency to sweat, giddiness, headache.

Behavior - Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face,

sighing or rapid respiration, facial pallor, swallowing,

**Section 5 – Very Basic PTS Screening**

Total 4 questions

Primary Care PTSD Screen (PC-PTSD)

Description - The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Instructions:

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

Have had nightmares about it or thought about it when you did not want to?

YES / NO

Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

YES / NO

Were constantly on guard, watchful, or easily startled?

YES / NO

Felt numb or detached from others, activities, or your surroundings

YES / NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

**Section 6 – General PTS Screening**

Total 18 questions

PTSD Questions - Do you experience:

Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?

Repeated, disturbing dreams of a stressful experience from the past?

Suddenly acting or feeling as if a stressful experience from the past were happening again

Suddenly acting or feeling as if a stressful experience from the past were happening again

Feeling very upset when something reminded you of a stressful experience from the past?

Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past

Avoiding thinking or talking about a stressful experience from the past or avoiding having feelings related to it?

Avoided activities or situations because they reminded you of a stressful experience from the past?

Having trouble remembering important parts of a stressful experience from the past?

Loss of interest in activities that you used to enjoy?

Feeling distant or cut off from other people?

Feeling emotionally numb or being unable to have loving feelings for those close to you?

Feeling as if your future somehow will be cut short?

Having trouble falling or staying asleep?

Feeling irritable or having angry outbursts?

Difficulty concentrating?

Being “super alert” or watchful or on guard?

Feeling jumpy or easily startled?

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