

Anxiety Questionnaire

Name Male Female Age _____ Date of Birth _____

Tobacco Use No Cigarettes Other tobacco _____ Date quit? _____

State _____ Amount of Insurance _____ Type of Insurance _____

Occupation/Source of income: _____

1. List Diagnosis: generalized anxiety disorder panic disorder obsessive compulsive agoraphobia post-traumatic stress syndrome _____

2. Date diagnosed: _____

3. List number of episodes and date of last episode: _____

4. Have you been hospitalized or seen in an emergency room for treatment of anxiety or other psychiatric illness? No

Yes, give details: _____

5. List all medications currently being taken for anxiety: _____

6. Have you had any of the following? If so, please give dates and details: _____

Depression No Yes: _____

Suicide Ideation or Thoughts No Yes: _____

Suicide Attempt No Yes: _____

Substance Abuse No Yes: _____

Personality Disorder or Psychotic Disorder No Yes: _____

General Questions:

1. Do you have any other major health problems? No Yes – Details: _____

2. List all medications: _____

3. Height: _____ Weight: _____ Most recent blood pressure reading: _____

Agent Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____