Name: __________________________ **DOB:** ____________________ **Date:** ___________________

Zung Self-Rating Anxiety Scale (SAS)

For each item below, please place a check mark (✓) in the column which best describes how often you felt or behaved this way during the past several days. Bring the completed form with you to the office for scoring and assessment during your office visit. √

Place check mark (✓) in the correct column	**A little of the time**	**Some of the time**	**Good part of the time**	**Most of the time**
1 I feel more nervous and anxious than usual				
2 I feel afraid for no reason at all.				
3 I get upset easily or feel panicky.				
4 I feel like I'm falling apart and going to pieces.				
5 I feel that everything is all right and nothing bad will happen				
6 My arms and legs shake and tremble.				
7 I am bothered by headaches, neck and back pain.				
8 I feel weak and get tired easily				
9 I feel calm and can sit still easily				
10 I can feel my heart beating fast				
11 I am bothered by dizzy spells				
12 I have fainting spells or feel like it				
13 I can breathe in and out easily				
14 I get feelings of numbness and tingling in my fingers and toes				
15 I am bothered by stomach aches or indigestion				
16 I have to empty my bladder often				
17 My hands are usually dry and warm				
18 My face gets hot and blushes				
19 I fall asleep easily and get a good night's rest				
20 I have nightmares				

Source: William W.K. Zung. A rating instrument for anxiety disorders. Pschosomatics, 1971