BAI®

PATIENT SELF-EVALUATION

Patient's name: Date:

Instructions: Indicate how much you have been bothered by each symptom during the past week, including today, by circling the number in the column that most closely corresponds to how you've been feeling.

		NOT AT ALL	**MILDLY** It did not bother me much.	**MODERATELY** It was very unpleasant but I could stand it.	**SEVERELY** I could barely stand it.
1	Numbness or tingling	0	1	2	3
2	Feeling hot	0	1	2	3
3	Wobbliness in legs	0	1	2	3
4	Unable to relax	0	1	2	3
5	Fear of the worst happening	0	1	2	3
6	Dizzy or lightheaded	0	1	2	3
7	Heart pounding or racing	0	1	2	3
8	Unsteady	0	1	2	3
9	Terrified	0	1	2	3
10	Nervous	0	1	2	3
11	Feelings of choking	0	1	2	3
12	Hands trembling	0	1	2	3
13	Shaky	0	1	2	3
14	Fear of losing control	0	1	2	3
15	Difficulty breathing	0	1	2	3
16	Fear of dying	0	1	2	3
17	Scared	0	1	2	3
18	Indigestion or discomfort in abdomen	0	1	2	3
19	Faint	0	1	2	3
20	Face flushed	0	1	2	3
21	Sweating (not due to heat)	0	1	2	3

Total Score:

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