



*Psychiatry and Transcranial Magnetic Stimulation*

## Hamilton Anxiety Scale

Date: \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Put a check mark in the box that BEST describes how you have felt in the last 2 weeks

Symptoms	Not Present	Mild	Moderate	Severe	Very Severe
<b>Anxiety</b> Worry, irritability, fearful anticipation					
<b>Tension</b> Restlessness, stress, inability to relax					
<b>Fear</b> Irrational phobia, excessive worry					
<b>Insomnia</b> Fatigue, inability to sleep, nightmares, night terrors					
<b>Intellectual Symptoms</b> Poor concentration, memory impairment					
<b>Depressed Mood</b> Decreased interest in activities, diurnal swing, early waking					
<b>Muscular Symptoms</b> Aches and pains, stiffness, twitching, teeth grinding					
<b>Sensory Symptoms</b> Tinnitus, blurred vision, hot/cold flushes, weakness					
<b>Cardiovascular Symptoms</b> Tachycardia, palpitations, chest pain, fainting, throbbing					
<b>Respiratory Symptoms</b> Chest pressure/constrictions, choking, sighing, dyspnea					
<b>Gastrointestinal Symptoms</b> Swallowing difficulties, abdominal pain, nausea, weight loss					
<b>Genitourinary Symptoms</b> Frequency/urgency of micturition, amenorrhea, impotence					
<b>Autonomic Symptoms</b> Dry mouth, flushing, pallor, sweating, giddiness, headache					
<b>Behavior at Interview</b> Fidgeting, restlessness, tremors, sighing, pallor, straining					