Zung Self-Rating Anxiety Scale (SAS)

Patient Name DOB Female

Provider Name Date Male Other

For each item below, please check the column which best describes how often you felt or behaved this way during the past several days.

	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 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.				

NOTES: