
Phobic Encounter Record

Instructions: Complete a separate copy of this form each time you encounter your feared object or situation.

Date: _____ Time: _____

Situation: _____

Maximum fear (use a 0–100 point scale): _____

Main bodily sensations (check)

Racing heart _____ Shortness of breath _____ Dizziness/unsteadiness _____

Chest tightness _____ Nausea _____ Sweating _____

Trembling _____ Numbness _____ Choking _____

Hot/cold _____ Sense of unreality _____

Other feelings: _____

Thoughts: _____

Behavior: _____

