
Worry Record

Date: _____ Time began: _____ (A.M./P.M.) Time ended: _____ (A.M./P.M.)

Maximum level of anxiety (circle a number below):

0----10----20----30----40----50----60----70----80----90----100
None Mild Moderate Strong Extreme

Indicate which of the following symptoms you are experiencing:

Restlessness, feeling keyed up or on edge _____
Easily fatigued _____
Difficulty concentrating or mind going blank _____
Irritability _____
Muscle tension _____
Sleep disturbance _____

Triggering events: _____

Anxious thoughts: _____

Anxious behaviors: _____

