

Hamilton Anxiety Rating Scale (HAM-A)

Below is a list of phrases that describe certain feeling that people have. Rate the patients by finding the answer which best describes the extent to which he/she has these conditions. Select one of the five responses for each of the fourteen questions.

0 = Not present, 1 = Mild, 2 = Moderate, 3 = Severe, 4 = Very severe.

<p>1 Anxious mood <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4</p> <p>Worries, anticipation of the worst, fearful anticipation, irritability.</p>	<p>8 Somatic (sensory) <input type="checkbox"/> 0 <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation.</p>
<p>2 Tension <input type="checkbox"/> 0 <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.</p>	<p>9 Cardiovascular symptoms <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat.</p>
<p>3 Fears <input checked="" type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.</p>	<p>10 Respiratory symptoms <input checked="" type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>Pressure or constriction in chest, choking feelings, sighing, dyspnea.</p>
<p>4 Insomnia <input checked="" type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.</p>	<p>11 Gastrointestinal symptoms <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>Difficulty in swallowing, wind abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation.</p>
<p>5 Intellectual <input type="checkbox"/> 0 <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>Difficulty in concentration, poor memory.</p>	<p>12 Genitourinary symptoms <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.</p>
<p>6 Depressed mood <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4</p> <p>Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.</p>	<p>13 Autonomic symptoms <input checked="" type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.</p>
<p>7 Somatic (muscular) <input checked="" type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone.</p>	<p>14 Behavior at interview <input type="checkbox"/> 0 <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, etc.</p>
<p>Total: 20</p>	