



INTUITIVE HYPNOSIS

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Anxiety – Panic Attacks

Name _____ Date _____

1. Have you been diagnosed with anxiety by a medical professional?

Yes No

If yes, how long ago? _____

Are you taking medication for this? Yes No

If yes, is it helping? _____

2. How long ago did the anxiety begin? _____

What else was happening at about that same time? _____

3. Do you wake up in the middle of the night with a panic/anxiety attack?

Yes No

If yes, how often? _____

How long do they last? _____

What do you do during one of these episodes? _____

4. Do you find yourself ruminating over specific events, conversations, etc.?

Yes No

If yes, what do you ruminate about? _____

5. Can you identify specific circumstances that trigger symptoms of anxiety?

6. Which of the following symptoms do you experience during a panic or anxiety attack?

- | | |
|---|--|
| <input type="checkbox"/> Accelerated heart rate | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Pressure across your chest | <input type="checkbox"/> Tingling in the hands |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Other – please describe |
| <input type="checkbox"/> Shakiness/jitteriness | _____ |
| <input type="checkbox"/> Sweaty face, palms, or other areas | _____ |
| <input type="checkbox"/> Chills | _____ |
| <input type="checkbox"/> Fog brain | _____ |

7. What have you used in the past to minimize the symptoms of anxiety?
(drugs/alcohol/exercise, etc.) _____

Did it work? Describe _____

8. As a child, did either of your parents exhibit signs of anxiety? Yes No

If yes, please describe. _____

9. Does your partner exhibit signs of anxiety? Yes No

If yes, please describe. _____

10. What does your anxiety keep you from doing that you would like to be doing? _____

11. What does your anxiety keep you from doing that you are glad you don't have to do, and it gives you a good reason not to do it? _____
