Name: _____

Date of Birth: _____

Today's Date: _____

Panic and Phobia Questionnaire

Please rate, on the following scale, the amount of fear that you think you would experience in each of the situations listed below if they were to occur in the next week. Try to imagine yourself actually doing each activity and how you would feel.

Fear Scale

0---------1--------2---------3---------4---------5---------6--------7--------8
no fear slight fear moderate fear marked fear extreme fear

1. Talking to people
2. Going through a car wash
3. Playing a vigorous sport on a hot day
4. Blowing up an airbed quickly
5. Eating in front of others
6. Hiking on a hot day
7. Getting gas at a dentist
8. Interrupting a meeting
9. Giving a speech
10. Exercising vigorously alone
11. Going long distances from home alone
12. Introducing yourself to groups
13. Walking alone in isolated areas
14. Driving on highways
15. Wearing striking clothes
16. Possibility of getting lost
17. Drinking a strong cup of coffee
18. Sitting in the center of a cinema
19. Running up stairs
20. Riding on a subway
21. Speaking on the telephone
22. Meeting strangers
23. Writing in front of others
24. Entering a room full of people
25. Staying overnight away from home
26. Feeling the effects of alcohol
27. Going over a long, low bridge.
28. Flying in an airplane

29. Using a computer
30. Having blood drawn for a lab test

Adapted from T.A. Brown et al. *Behaviour Research and Therapy* 43 (2005) 337–355