

Severity Measure for Specific Phobia—Adult

Name: _____ Age: _____ Sex: Male Female Date: _____

The following questions ask about thoughts, feelings, and behaviors that you may have had in a variety of situations. Please check (✓) the item below that makes you most anxious. <u>Choose only one item and make your ratings based on the situations included in that item.</u>											
<input type="checkbox"/> Driving, flying, tunnels, bridges, or enclosed spaces	<input type="checkbox"/> Animals or insects	<input type="checkbox"/> Heights, storms, or water	<input type="checkbox"/> Blood, needles, or injections	<input type="checkbox"/> Choking or vomiting							
Please respond to each item by marking (✓ or x) one box per row.						Clinician Use					
During the PAST 7 DAYS, I have...						Never	Occasionally	Half of the time	Most of the time	All of the time	Item score
1.	felt moments of sudden terror, fear, or fright in these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
2.	felt anxious, worried, or nervous about these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
3.	had thoughts of being injured, overcome with fear, or other bad things happening in these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky in these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing in these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
6.	avoided, or did not approach or enter, these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
7.	moved away from these situations or left them early	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
8.	spent a lot of time preparing for, or procrastinating about (i.e., putting off), these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
9.	distracted myself to avoid thinking about these situations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
10.	needed help to cope with these situations (e.g., alcohol or medications, superstitious objects, other people)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					
Total/Partial Raw Score:											
Prorated Total Raw Score: (if 1-2 items left unanswered)											
Average Total Score:											

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