Hamilton Anxiety Scale (HAM-A)

Instructions to Subject: I would like to ask you some questions about the past week. In responding to the questions, think about your thoughts and feelings from last (name day of week) until today.

1	**Anxious mood.** What has your mood been like this past week? Have you been feeling worried or anticipating the worst? Have you had feelings of fearful anticipation or irritability?
2	**Tension**. In the past week, have you had any feelings of tension or fatigability? Have you startled easily? Have you been moved to tears easily? Any trembling? Any feelings of restlessness or feeling unable to relax?
3	**Fears.** In the past week, have you felt fearful of the dark? Fearful of strangers? Of being left alone? Of animals? Of traffic? Of crowds?
4	**Insomnia.** How have you been sleeping over the past week? Have you had any difficulty or trouble falling asleep in the beginning of the night? How long has it been taking you to fall asleep compared to usual? How about feeling that your sleeping has been restless, disturbed or unsatisfying some nights? Have you been waking up in the middle of the night? Have you felt tired or fatigued upon waking in the morning? Any bad dreams, nightmares or night terrors?
5	**Intellectual (cognitive).** In the past week, have you had difficulty concentrating (e.g., while reading a book or magazine, watching television, having a conversation, driving, etc.)? Have you had any difficulty remembering things? How has your memory been compared to usual (i.e., before you began feeling anxious)?
6	**Depressed mood.** In the past week, have you had any depressed feelings (e.g., down, sad, blue, hopeless, crying a lot, etc.)? How about feeling a loss of interest or lack of pleasure in hobbies or other daily activities? Any early morning awakening? How about feeling better or worse at any particular time of day, for example, in the morning or the evening? How much worse do you feel in the a.m. or p.m.?
7	**Somatic (muscular).** How have you been feeling physically the past week? Have you experienced any of the following: pains and aches? twitching of your muscles? any stiffness? grinding of your teeth? an unsteady voice? increased muscular tone? muscle contractions or jerking?
8	**Somatic (sensory).** Have you experienced any ringing in your ears over the past week? How about buzzing, clicking or roaring sounds? Any blurring of your vision? Hot and cold flashes? Feelings of physical weakness? A pricking sensation?
9	**Cardiovascular symptoms.** Over the past week, have you experienced an increase in your heart rate or felt your heart beating rapidly? Have you had any pain in your chest? Throbbing of your vessels? Feelings that you might faint? Have you felt your heart missing beats?

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10	**Respiratory symptoms.** In the past week, have you experienced any pressure or constriction in your chest? Any choking feelings? More sighing than usual? Any difficult or labored breathing? Shortness of breath?
11	**Gastrointestinal symptoms**. Over the past week, have you experienced any abdominal/stomach pain or discomfort? Have you had any difficulty in swallowing? More wind than usual? Any burning sensations in your abdomen? Any feelings of abdominal fullness or feeling distended? Any feeling of nausea? Vomiting? Any rumbling or noises in your stomach more than is usual for you? Any looseness of the bowels or diarrhea? Any constipation? How about loss of weight? (For loss of weight, rate 0=less than 1 pound; 1=at least 1 pound but less than 2 pounds; 2=at least 2 pounds but less than 4 pounds; 3=4 or more pounds; 4=incapacitating.)
12	**Genitourinary symptoms.** In the past week, have you been urinating more frequently than is usual for you? Have you felt a greater urgency to urinate than is usual for you? Have you experienced an absence or abnormal stoppage of you menses or period? How about excessive flow or bleeding during you menses or period? Have you felt sexually cold or unresponsive (i.e., frigid) during the past week? Any loss of sexual interest or drive (i.e., libido)? Have you experienced premature ejaculation? Have you experienced sexual impotence?
13	**Autonomic symptoms.** In the past week, have you experienced any of the following symptoms: dry mouth? more sweating than usual? flushing? pallour? dizziness? tension headache? raising of hair?
14	**Behavior at interview (general).** Rate and assess for the presence of any of the following symptoms and/or behaviours during the interview: fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid breathing, facial pallor, swelling, belching, brisk tendon jerks, dilated pupils, protruding eyes (exophthalmos).

Hamilton Anxiety Scale (HAM-A) Severity Rating Scale Definitions

Value	Meaning	Definition	Criteria for severity ratings
0	Absent		
1	Mild	Occurs irregularly and for short periods of time.	Rate MILD if symptom is present, but less than 50% of the time. How often do these feelings/ symptoms occur? How often do they last (short or long periods)?
2	Moderate	Occurs more constantly and of longer duration requiring considerable effort on part of subject to cope with it.	Rate MODERATE if symptom is present more than 50% of the time, but not continuous. Are the symptoms present more constantly or more often or not? Are they more present than absent, or vice versa, or are they present more or less than 50% of the time?
3	Severe	Continuous and dominates subjects life.	Rate SEVERE if symptom is present continuously. Have these feelings/symptoms been continuous? Do they dominate your life? How so?
4	Very severe	Incapicating.	Rate VERY SEVERE if symptom is incapicating. Have you been incapacitated by these feelings/symptoms? (Look for inability to care for self, profound social or occupational impairment, inability to get around without help, most areas of life interrupted. For in-subjects: unable to attend unit activities, doctors sessions, groups, activities therapy, community meetings, unable to attend to personal hygiene, etc. For out-subjects: includes inability to function in job, disrupted personal relationships, inability to care for self, etc.). Have you been unable to function because of these feelings or symptoms? What ares of your life have been interrupted/affected?

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For each item (1-14), circle the number that best characterizes the subject. Refer to the 0-4 scale point definitions and criteria for symptom severity ratings on facing page. MOST IMPORTANT, refer to the criteria for symptom severity ratings, which more precisely defines each severity rating scale point

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NOTE: Use the questions (1-14) on the HAMILTON ANXIETY SCALE (HAM-A) WORKSHEET to obtain information needed to make each severity rating.

NOTE: Some symptoms can be medication side effects (e.g., dry mouth, blurred vision, abdominal discomfort). Carefully assess whether a symptom might be due to a medication or to anxiety. If a symptom is judged to be related to medication, do not rate as present.

Circle one number on each line

		Absent	Mild	Moderate	Severe	Very severe
1	Anxious mood	0	1	2	3	4
2	Tension	0	1	2	3	4
3	Fears	0	1	2	3	4
4	Insomnia	0	1	2	3	4
5	Intellectual (cognitive)	0	1	2	3	4
6	Depressed mood	0	1	2	3	4
7	Somatic (muscular)	0	1	2	3	4
8	Somatic (sensory)	0	1	2	3	4
9	Cardiovascular symptoms	0	1	2	3	4
10	Respiratory symptoms	0	1	2	3	4
11	Gastrointestinal symptoms	0	1	2	3	4
12	Genitourinary symptoms	0	1	2	3	4
13	Autonomic symptoms	0	1	2	3	4
14	Behaviour at interview (general)	0	1	2	3	4
	Total score for each column					

Grand total (sum of 5 column totals) |