Panic Attack Record

Date ____ /____ /____ Time Began ______ A.M./P.M. Duration: ______ (mins.)

With: ☐ Alone ☐ Friend ☐ Stranger ☐ Family

Stressful Situation? ☐ Yes ☐ No ____________________

Expected? ☐ Yes ☐ No

Maximum Fear *(circle)*

0	1	2	3	4	5	6	7	8
None		Mild		Moderate		Strong		Extreme

Symptoms *(underline the first symptom and check all symptoms present):*

☐ Difficulty Breathing
☐ Racing/Pounding Heart
☐ Choking Sensations
☐ Sweating
☐ Trembling/Shaking
☐ Nausea/Abdominal Upset
☐ Fear of Losing Control/ Going Crazy
☐ Chest Pain/Discomfort
☐ Hot/Cold Flashes
☐ Numbness/Tingling
☐ Feelings of Unreality
☐ Unsteadiness/Dizziness/ Fainting
☐ Fear of Dying

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