

Panic Attack Record

Fill out one form for each separate panic attack.

Date: _____ Time panic attack started: _____ Duration of attack: _____

Intensity of panic at peak (0-10): _____

1. Identified triggers: _____
2. Where you were when panic attack began: _____
3. What you were doing when panic attack began: _____
4. Stress level during preceding day (rate on a 1 to 10 scale where 1 is the lowest stress level and 10 is the highest): _____
5. Were you... Alone With someone (specify): _____
6. Your mood for the 3 hours preceding the panic attack:
 Anxious Depressed Excited Angry Sad
 Other (specify): _____
7. Were you... facing a challenge taking it easy
8. Were you engaging in negative or fearful thoughts before you panicked? Yes No
9. Were you... tired rested
10. Were you experiencing some kind of emotional upset or loss? Yes No
11. Were you feeling... hot cold neither
12. Were you feeling restless or impatient? Yes No
13. Were you asleep before you panicked? Yes No
14. Did you consume caffeine or sugar within eight hours before you panicked?
 Yes No If yes, how much? _____
15. Check all physical symptoms present to at least a mild degree:

<input type="checkbox"/> Chest pain or discomfort	<input type="checkbox"/> Shaking/trembling
<input type="checkbox"/> Sweating	<input type="checkbox"/> Chills/hot flushes
<input type="checkbox"/> Heart racing/palpitations/pounding	<input type="checkbox"/> Numbness/tingling
<input type="checkbox"/> Nausea/upset stomach	<input type="checkbox"/> Feelings of choking
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Fear of dying
<input type="checkbox"/> Dizzy/unsteady/lightheaded/faint	<input type="checkbox"/> Fear of losing control/going insane

16. Thoughts going through your mind:

a. Before panic attack:

b. During panic attack:

c. After panic attack:

17. How you responded to panic attack (seek help, lie down, exit where you were, etc.):
