Please complete this form and show it to your doctor or other healthcare professional.

Do you have a Specific Phobia?

1. Do you have a serious and persistent fear of a specific object or situation (such as flying, heights, animals, receiving an injection, or seeing blood)?
   - YES
   - NO

2. Do you feel anxious almost every time you encounter this specific object or situation?
   - YES
   - NO

3. Is this fear excessive or unreasonable?
   - YES
   - NO

4. Do you go out of your way to avoid feared objects or situations?
   - YES
   - NO

5. If you cannot avoid a feared object or situation, do you feel intense anxiety or distress?
   - YES
   - NO

6. Does the fear of avoidance interfere significantly with your normal routine, occupational (academic) functioning, or social activities or relationships?
   - YES
   - NO

7. Do you feel very distressed about having this fear?
   - YES
   - NO

You **might** have a Specific Phobia if all of the following are **true**:

- You answered YES to items 1, 2, and 3
- You answered YES to at least one of items 4 and 5
- You answered YES to at least one of items 6 and 7

Note: This questionnaire is for informational purposes only and is not intended to function as a psychological or psychiatric assessment. Diagnosis of psychiatric disorders requires a careful evaluation by a trained professional.

To get help for this condition or to receive a comprehensive assessment, please call The Institute of Living's Anxiety Disorders Center at (860) 545-7685.