Patient-Directed Agoraphobia Self-Report Tool

Patient Name: _____ Date: _____

	YES	NO
1. Were there places where you felt afraid or that you avoided because you thought it could be difficult to get help or to easily leave?		
2. Did you have intense fear or anxiety about at least 2 of the following 5 groups of situations?		
(1) Public transportation (e.g., traveling in automobiles, buses, trains, ships, or planes)		
(2) Open spaces (e.g., parking lots, marketplaces, or bridges)		
(3) Being in shops, theaters, or cinemas		
(4) Standing in line or being in a crowd		
(5) Being outside the home alone in other situations		
3. Did you fear or avoid these situations due to thoughts that escape might be difficult or help might not be available in the event of panic-like symptoms or other incapacitating or embarrassing symptoms (e.g., fear of falling in the elderly; fear of incontinence)?		
4. Did you require the presence of a companion or endure the situation with marked fear or anxiety?		
5. Was the fear or anxiety out of proportion to the actual danger posed by the agoraphobic situation?		
6. Did the fear, anxiety, or avoidance persist, typically lasting longer than 6 months?		

FOR CLINICIAN USE

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If 1–6 are coded Yes, the results are consistent with a diagnosis of agoraphobia, with further assessment required.