

# Panic Attack Record

<b>Date &amp; Time</b>	<b>Fear rating (0-100%)</b>
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<b>Situation or Activity</b> Where were you? Who were you with?	<b>Trigger</b> What do you think caused your panic to start at that moment?
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<b>Symptoms</b>	<input type="checkbox"/> Heart pounding, racing, or palpitations <input type="checkbox"/> Sweating <input type="checkbox"/> Trembling or shaking <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Feelings of choking <input type="checkbox"/> Chest pain or discomfort <input type="checkbox"/> Nausea or stomach distress <input type="checkbox"/> Dizziness, lightheadedness, or feeling faint <input type="checkbox"/> Chills or hot flashes <input type="checkbox"/> Numbness or tingling <input type="checkbox"/> Feelings of unreality <input type="checkbox"/> Fear of losing control or going crazy <input type="checkbox"/> Fear of dying
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<b>Thoughts (or images)</b> What was going through your mind? What were you predicting would happen?
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<b>Coping strategy</b> What did you do to cope? What action did you take to make yourself feel better?
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