MODIFIED SOMATIC PERCEPTION QUESTIONNAIRE

Patient Name _____ Date_____

Please read carefully:

Please describe how you have felt during the PAST WEEK by checking the closest description of each item.
Mark only one answer to each question.

SYMPTOM	NOT AT ALL	A LITTLE, SLIGHTLY	A GREAT DEAL, QUITE A BIT	EXTREMELY, COULD NOT HAVE BEEN WORSE
1. Heart rate increase				
2. Feeling hot all over				
3. Sweating all over				
4. Sweating in a particular part of the body				
5. Pulse in neck				
6. Pounding in head				
7. Dizziness				
8. Blurred vision				
9. Feeling faint				
10. Everything appearing unreal				
11. Nausea				
12. Butterflies in stomach				
13. Pain or ache in stomach				
14. Stomach churning				
15. Desire to pass water				
16. Mouth becoming dry				
17. Difficulty swallowing				
18. Muscles in neck aching				
19. Legs feeling weak				
20. Muscles twitching or jumping				
21. Tense feeling across forehead				
22. Tense feeling in jaw muscles				

COMMENTS: _____

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EXAMINER: _____

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