



Name _____

Date ____ / ____ / ____

ASSESSING YOUR FEARS

Please ✓check the box after each entry that most closely describes your usual experience. Leave blank any objects or situations that do not cause any discomfort.

<u>Feared Objects, Situations</u>	<u>Mild Discomfort</u>	<u>Moderate Discomfort</u>	<u>Severe Discomfort</u>
Accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Airplanes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being alone.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being in a new place.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bridges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cemeteries.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling insects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Criticism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crowded rooms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crowds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Darkness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dead animals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dead bodies.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deep water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dirt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving an automobile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please turn the page over and complete the work sheet ➡



JUDIE KEYS, C.C.H. Director • Hypnotherapist • Life and Business Coach
Address: 1761 Hotel Circle S , Ste 356 • San Diego CA 92108-3318
Cell/Text 619 961-7555
Email: judiekeysch@HealingMagicInternational.com
Website:www.HealingMagicInternational.com

<u>Feared Objects, Situations</u>	<u>Mild Discomfort</u>	<u>Moderate Discomfort</u>	<u>Severe Discomfort</u>
Earthquakes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevators.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enclosed places.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling disapproved of.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling rejected.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flying insects.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guns.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harmless snakes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heights.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Illness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injections.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Losing control.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loud voices.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meeting a stranger.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People in authority.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prospect of surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public speaking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rats and/or mice.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sharp objects.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sick people.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sirens.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spiders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden noises.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suffocating.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thunderstorms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trains or buses.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking alone.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wounds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other fears (specify)			
_____.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

