

# DSM-5 Generalized Anxiety Disorder Checklist

Name:

Date:

**Instructions:** Respond honestly to each question with "Yes" or "No."

Questions	YES	NO
Do you feel nervous, anxious, or on edge most of the time?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble controlling your worry?	<input type="checkbox"/>	<input type="checkbox"/>
Do you worry too much about various aspects of life (e.g., health, finances, relationships, work)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience difficulty in relaxing?	<input type="checkbox"/>	<input type="checkbox"/>
Are you often restless and find it challenging to sit still?	<input type="checkbox"/>	<input type="checkbox"/>
Do you become easily irritated or feel on edge?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience muscle tension or physical symptoms of anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
Are you frequently fatigued or lacking energy?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty concentrating or often feel your mind going blank?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have sleep disturbances, such as difficulty falling or staying asleep, or restless and unsatisfying sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience excessive worry about future events or situations, even when there is little or no reason to be concerned?	<input type="checkbox"/>	<input type="checkbox"/>
Are you constantly preoccupied with potential negative outcomes or "what-if" scenarios?	<input type="checkbox"/>	<input type="checkbox"/>

Do you feel a sense of impending doom or constant fear of something bad happening?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed physical symptoms like headaches, stomachaches, or other unexplained pains that may be related to anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
Does your anxiety interfere significantly with your daily activities, work, or school performance?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been experiencing these symptoms for at least six months or longer?	<input type="checkbox"/>	<input type="checkbox"/>
Have you sought help or professional advice for your anxiety symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Are you experiencing symptoms of panic attacks, such as heart palpitations, shortness of breath, or a feeling of impending doom?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently noticed any avoidance behaviors, such as avoiding social situations or places that trigger your anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced a sudden increase in anxiety or panic symptoms that are causing significant distress in the past 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>

<b>TOTAL SCORE</b>	
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**Score Interpretation:** Each "Yes" response receives a value of 1, and each "No" response receives a value of 0.

Add up all the values to get the total score, which ranges from 0 to 20.

Interpretation of the total score:

- **0 to 4:** Mild anxiety symptoms
- **5 to 9:** Moderate anxiety symptoms
- **10 to 14:** Moderately severe anxiety symptoms
- **15 to 20:** Severe anxiety symptoms