

General Anxiety Disorder Assessment (GAD-7)

Name	Date
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Over the last <u>two weeks</u> , how often have you experienced these symptoms?	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Worrying too much about different things?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Trouble relaxing?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Being so restless that it is hard to sit still?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Becoming easily annoyed or irritable?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling afraid as if something awful might happen?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Score	Risk level	
0-4	Minimal anxiety	Add the score for each column: + +
5-9	Mild anxiety	
10-14	Moderate anxiety	Total score: _____
15-21	Severe anxiety	_____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all
 Somewhat difficult
 Very difficult
 Extremely difficult

Notes