

# Geriatric Anxiety Scale

Full Name: \_\_\_\_\_ Date Submitted: \_\_\_\_\_

**Instructions:** Below is a list of anxiety/stress symptoms. Please indicate how often you experienced each symptom during the past week up to now before answering the scale.

ITEM	Not at all	Sometimes	Most of the time	All of the time
1. My heart raced or beat strongly.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
2. My breath was short.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
3. I had an upset stomach.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
4. I felt like things were not real or like I was outside of myself.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
5. I felt like I was losing control.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
6. I was afraid of being judged by others.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
7. I was afraid of being humiliated or embarrassed.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
8. I had difficulty falling asleep.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
9. I had difficulty staying asleep.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
10. I was irritable.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
11. I had outbursts of anger.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
12. I had difficulty concentrating.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
13. I was easily startled or upset.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
14. I was less interested in doing something I typically enjoy.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
15. I felt detached or isolated from others.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
16. I felt like I was in a daze.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
17. I had a hard time sitting still.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
18. I worried too much.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
19. I could not control my worry.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
20. I felt restless, keyed up, or on edge.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
21. I felt tired.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
22. My muscles were tense.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
23. I had back pain, neck pain, or muscle cramps.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
24. I felt like I had no control over my life.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
25. I felt like something terrible was going to happen to me.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
26. I was concerned about my finances.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
27. I was concerned about my health	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>

28. I was concerned about my children.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
29. I was afraid of dying.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>
30. 30. I was afraid of becoming a burden to my family or children.	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>

**Scoring**

The total score will be the sum of Items 1 to 25. There are also subscale scores to calculate:

- Somatic = Items 1-3, 8, 9, 17, 21-23      **Total Score:** \_\_\_\_\_
- Cognitive = Items 4-5, 12, 16, 18-19, 24-25      **Total Score:** \_\_\_\_\_
- Affective = Items 6, 7, 10-11, 13-15, 20      **Total Score:** \_\_\_\_\_
- **Overall Total Score:** \_\_\_\_\_

**Additional Comments**

Segal, D. L., June, A., Payne, M., Coolidge, F. L., & Yochim, B. (2010). Development and initial validation of a self-report assessment tool for anxiety among older adults: The Geriatric Anxiety Scale. *Journal of Anxiety Disorders*, 24, 709-714.