Date:_____

Anxiety Questionnaire (GAD 7)

Patient Name: _____ Birth Date: _____

Name of person helping the patient complete this form? _____

GAD-7 (Anxiety)				
Not at all	Many days	More than half the days	Nearly every day	**Over the last 2 weeks, how often have you been bothered by any of the following problems?**
☐0	☐1	☐2	☐3	1. Feeling nervous, anxious or on edge
☐0	☐1	☐2	☐3	2. Not being able to stop or control worrying
☐0	☐1	☐2	☐3	3. Worrying too much about different things
☐0	☐1	☐2	☐3	4. Trouble relaxing
☐0	☐1	☐2	☐3	5. Being so restless that it is hard to sit still
☐0	☐1	☐2	☐3	6. Becoming easily annoyed or irritable
☐0	☐1	☐2	☐3	7. Feeling afraid as if something awful might happen
Total Score =				
Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐				If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?