

Patient Name: _____ Date of Birth ___ / ___ / ___ Date: _____

The GAD-7 Anxiety Scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it's hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>				
<i>Total Score (add your column scores)</i>				

If you checked off any problems, how difficult have these problems 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 ____