

General Anxiety Disorder (GAD-7)

NAME _____

DATE _____

| | Not at all sure | Several days | Over half the days | Nearly every day |
|---|----------------------------|----------------------------|----------------------------|----------------------------|
| 1. Over the last 2 weeks, how often have you been bothered by the following problems? | | | | |
| • 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's 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 |
| <i>Add the score for each column</i> | | | | |
| TOTAL SCORE <i>(add your column scores)</i> | | | | |
| | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
| 2. If you checked off any problem on this questionnaire so far, 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? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |