CARROLL-DAVIDSON GENERALIZED ANXIETY DISORDER SCREEN

■ These questions are to ask about things you may have felt most days in the past six months.	YES	NO	Staff Use Only
1. Most days I feel very nervous.	☐	☐	
2. Most days I worry about lots of things.	☐	☐	
3. Most days I cannot stop worrying.	☐	☐	
4. Most days my worry is hard to control.	☐	☐	
5. I feel restless, keyed up or on edge.	☐	☐	
6. I get tired easily.	☐	☐	
7. I have trouble concentrating.	☐	☐	
8. I am easily annoyed or irritated.	☐	☐	
9. My muscles are tense and tight.	☐	☐	
10. I have trouble sleeping.	☐	☐	
11. Did the things you noted above affect your daily life (home life, or work, or leisure) or cause you a lot of distress?	☐	☐	
12. Were the things you noted above bad enough that you thought about getting help for them?	☐	☐	
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MODIFIED SPRINT (SPRINT-4) PTSD SCREEN

If at any time you have experienced or witnessed a traumatic event, which involves loss of life, serious injury or threat of either: ■ **Please respond to these questions about how you have felt most days in the past week.**	YES	NO	Staff Use Only
1. Have you been bothered by unwanted memories, nightmares, or reminders of this event?	☐	☐	
2. Have you been making an effort to avoid thinking or talking about this event, or doing things which remind you of what happened?	☐	☐	
3. Have you lost enjoyment for things, kept your distance from people, or found it difficult to experience feelings?	☐	☐	
4. Have you been bothered by poor sleep, poor concentration, jumpiness, irritability, or feeling watchful around you?	☐	☐	
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THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

PLEASE RETURN THIS FORM TO STAFF FOR SCORING.

SCREENING RECOMMENDATION (TO BE FILLED OUT BY CLINICIAN ONLY)

■ **I spoke with the participant and recommended: (Check all that apply)**

Follow-up for:
☐ Depression ☐ Bipolar Disorder ☐ No follow-up needed
☐ Generalized Anxiety Disorder ☐ Post-Traumatic Stress Disorder

■ **If a Community-Based Site:**
☐ Outpatient Referral
☐ Inpatient Referral
- ☐ Voluntary
- ☐ Emergency

■ **If a Primary Care Facility:**
☐ Treated in office
☐ Referred Elsewhere
☐ Emergency

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