GAD-7 Anxiety Assessment

Name: _____ **Date:** _____ dd / mm / yyyy

Over the last two weeks, how often have you experienced these symptoms? Choose one answer per question.

Feeling nervous, anxious, or on edge?

◯ Not at all (0) ◯ Several Days (1) ◯ More than half the days (2) ◯ Nearly every day (3)

Not being able to stop or control worrying?

◯ Not at all (0) ◯ Several Days (1) ◯ More than half the days (2) ◯ Nearly every day (3)

Worrying too much about different things?

◯ Not at all (0) ◯ Several Days (1) ◯ More than half the days (2) ◯ Nearly every day (3)

Trouble relaxing?

◯ Not at all (0) ◯ Several Days (1) ◯ More than half the days (2) ◯ Nearly every day (3)

Being so restless that it is hard to sit still?

◯ Not at all (0) ◯ Several Days (1) ◯ More than half the days (2) ◯ Nearly every day (3)

Becoming easily annoyed or irritable?

◯ Not at all (0) ◯ Several Days (1) ◯ More than half the days (2) ◯ Nearly every day (3)

Feeling afraid as if something awful might happen?

◯ Not at all (0) ◯ Several Days (1) ◯ More than half the days (2) ◯ Nearly every day (3)

TOTAL SCORE: _____

If you checked any problems, how difficult have they 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