PATIENT NAME:_____ DATE:_____

## GAD - 7

| **OVER THE LAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS? (Please check the appropriate boxes.)** | **NOT AT ALL** | **SEVERAL DAYS** | **MORE THAN HALF THE DAYS** | **NEARLY EVERY DAY** |
|---|---|---|---|---|
| 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 | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |

For Office Coding _____ + _____ + _____ + _____

=Total Score:_____