

Client Name: _____

Date of Birth: _____

Generalized Anxiety Disorder 7-item (GAD-7) 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
1. Feeling nervous, anxious, or on edge	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
2. Not being able to stop or control worrying	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
3. Worrying too much about different things	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
4. Trouble relaxing	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
5. 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)
6. becoming easily annoyed or irritable	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
7. 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>) =	_____			

If you checked off any problems, how difficult have these 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