

Client Name: _____

Date: _____

Anxiety Questionnaire (GAD-7)

Over the **last 2 weeks**, how often have you been bothered by the following problems?

(Circle your answer)

Not at all Several Day 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

Total Score: _____

If you checked off **any** problem, how **difficult** have these problems made it for you to do work, take care of things at home, or get along with other people?

Not difficult at all: _____ Somewhat difficult: _____ Very difficult: _____ Extremely Difficult: _____

Scoring GAD-7 Anxiety Severity

Normal	Mild	Moderate	Severe
0-4	5-9	10-14	15-21