GAD7 ANXIETY QUESTIONNAIRE

Name: **NHI:** **Date:**

Over the **last two weeks,** how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)

	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's 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
Add Columns				
TOTAL				

8. If you checked off any problems, how difficult have these problems 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

9. How would you rate your overall quality of life? On a scale of 1(lowest) to 10 (highest)	
10. How satisfied are with your health? On a scale of 1(lowest) to 10 (highest)	

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Inern Med. 2006;166:1092-1097.