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Generalized Anxiety Disorder Screening GAD-7

Name: _____ DOB: _____ Date: _____

Seven Symptom Checklist

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

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
	0	**1**	**2**	**3**
a. Excessive anxiety and worry about 2 or more events or activities and difficulty controlling the worry...				
b. Restlessness or feeling keyed up or on edge...				
c. Being easily fatigued...				
d. Difficulty concentrating or mind going blank...				
e. Irritability...				
f. Muscle tension (trembling, twitching, feeling shaky)...				
g. Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)...				

Total Score: _____

2. If you checked off any problem on this questionnaire, 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