Patient Name ______________________ Self-Evaluation Form Patient DOB ______________________

ANXIETY QUESTIONNAIRE (GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use a ✓ or ◯ to indicate your answer)*	**Date of Completion**	_____ / _____ / 20____

	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 might happen	0	1	2	3
		(Total) +	(Total) +	(Total)
	Total Score			

⑧ If you checked any of the 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

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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