Family Care Physicians, P.C.
Anxiety and Depression Institute
Patient Health Questionnaire General Anxiety Disorder (GAD-7)

Date: Patient Name: Date of Birth:

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please click the check mark by your answers.

GAD-7	Not at all sure	Several days	Over 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 the score for each column				

Total Score (add your column scores):

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? (Please check one)

☐ **Not difficult at all.** ☐ **Somewhat difficult.** ☐ **Very Difficult.** ☐ **Extremely Difficult.**