

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### The Generalized Anxiety Disorder 7-Item Scale

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems?	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 awful might happen	0	1	2	3

**Total Score:**  = **Add Columns** 0 + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_

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 at all**                      **Somewhat difficult**                      **Very difficult**                      **Extremely Difficult**

\_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_

#### Interpreting the Score:

Total Score	Interpretation
≥10	Possible diagnosis of GAD; confirm by further evaluation
5	Mild Anxiety
10	Moderate anxiety
15	Severe anxiety