

Patient Health Questionnaire (GAD-7)

Name: **Date:**

Over the last 2 wks, 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
Feeling nervous, anxious, or on edge	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Not being able to stop or control worrying	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Worrying too much about different things	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Trouble relaxing	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Being so restless that is hard to sit still	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Becoming easily annoyed or irritable	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Feeling afraid as if something awful might happen	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Total = <input style="width: 100px; height: 25px;" type="text"/>	<input style="width: 60px; height: 25px;" type="text"/>	<input style="width: 60px; height: 25px;" type="text"/>	<input style="width: 60px; height: 25px;" type="text"/>	<input style="width: 60px; height: 25px;" type="text"/>
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 <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>