Anxiety GAD7

When 1a + 1b ≥ 3, if 1c is ≥ 1

 PATIENT ASSESSMENT

**Patient Name: DOB:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 |
| 1. Feeling nervous, anxious, or on edge
 | 0 | 1 | 2 | 3 |
| 1. Not being able to stop or control worrying
 | 0 | 1 | 2 | 3 |
| 1. Worrying too much about different things
 | 0 | 1 | 2 | 3 |
| 1. Trouble relaxing
 | 0 | 1 | 2 | 3 |
| 1. Being so restless that it’s hard to sit still
 | 0 | 1 | 2 | 3 |
| 1. Becoming easily annoyed or irritable
 | 0 | 1 | 2 | 3 |
| 1. Feeling afraid as if something awful might happen
 | 0 | 1 | 2 | 3 |
| 1. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual
 | 0 | 1 | 2 | 3 |
| 1. 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 | Somewhat difficult | Very difficult | Extremely difficult |
| *FOR OFFICE USE ONLY* | add columns | + | + |  |
| *No Risk: 1-4; Low Risk: 5-9; Moderate Risk: 10-14; High Risk: 15-21**Refer to Behavioral Health for totals of 10 or more* |  TOTAL |  |  |  |