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GENERALIZED ANXIETY DISORDER SCALE (GAD-7)

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1) Feeling nervous, anxious, or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Not being able to stop or control worrying:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Worrying too much about different things:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Trouble relaxing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Being so restless that it is hard to sit still:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Becoming easily annoyed or irritable:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Feeling afraid as if something awful might happen:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score:

If you check any problems, how difficult have they 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

Interpretation of Total

___ (5-9) Mild

___ (10-14) Moderate

___ (15 and over) Severe