



ANXIETY SCREENING (GAD-7)

Your Answers Help Us Understand and Support Your Care

1 PATIENT INFORMATION

Patient Name: _____

Date: _____

2 OVER THE LAST 2 WEEKS

Mark how often each symptom has bothered you: 0 = Not at all, 1 = Several days, 2 = More than half the days, 3 = Nearly every day.

Symptom	0	1	2	3
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless it is hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Total Score: _____				

3 FUNCTIONAL IMPACT

How difficult have these problems made work, home responsibilities, or relationships?

☐ Not difficult at all

☐ Very difficult

☐ Somewhat difficult

☐ Extremely difficult

4 CLINICIAN USE

Reviewed By: _____

Date: _____

Clinical Notes / Follow-up: _____