RevereHealth
Your health above all else

GAD-7 Anxiety Scale

For each of these items, check the box that best describes your behavior. Please complete this as if it were your WORST day!

Name: ______________________ **Gender:** ________ **Date:** ______________

	Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than ½ 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
		Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	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?	0	1	2	3

Source: Primary Care Evaluation of Mental Disorders patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD is a trademark of Pfizer Inc. Copyright 1999 Pfizer Inc. All rights reserved. Reproduced with permission.