



Anxiety Screening (GAD-7)

PATIENT QUESTIONNAIRE

PATIENT DOB MRN DATE

Generalized Anxiety Disorder Screen (GAD-7)

Over the **last two weeks**, how often have you been bothered by the following problems? Check one box on each line.

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

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

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PATIENT SIGNATURE _____ DATE _____

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Total score 0–4 minimal · 5–9 mild · 10–14 moderate · 15–21 severe · ≥20 warrants further evaluation

Result ☐ Negative ☐ Positive ☐ Patient declined screening

Follow-up ☐ None needed ☐ Advised follow-up with primary care ☐ Existing diagnosis and care plan
☐ Behavioral health referral

Notes

PROVIDER SIGNATURE _____ DATE _____

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