CLIENT FULL NAME:	**DATE OF BIRTH:** (MON-DD-YYYY)
THERAPIST NAME:	**DATE COMPLETED:** (MON-DD-YYYY)

GENERALIZED ANXIETY DISORDER QUESTIONNAIRE (GAD-7)

Please read this carefully. *Please answer* ***ALL*** *questions below by clicking on the button which you think most nearly applies to you. Please hand in the completed questionnaire to your therapist.*

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use **X** or ✓ to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
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?	☐	☐	☐	☐

Client Signature: ______________________________________

*__Completed By:__ __________________________________ **Role:** ____________________________

**If questionnaire was completed on behalf of the client*

The GAD-7 originates from Spitzer RL, Kroenke K, Williams JB, et al; A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. *GAD-7 © Pfizer Inc. all rights reserved; used with permission.*