Partners in Family Medicine - Troy
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(518) 274-0024

Name: ______________________________ DOB: ______________________

Today's Date: ____________________

GAD

Over the **last 2 weeks**, how often have you been bothered by the following problems? (Circle your answers)	**Not at all**	**Several Days**	**More than half 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

(For office coding: Total Score T ________ = ________ + ________ + ________