Summer Care Home – Mental Health Clinic
GAD-7 – Anxiety Screening

GAD-7: GENERALISED ANXIETY DISORDER SCALE

Anxiety Screening Tool (Spitzer et al., 2006)

Over the last 2 weeks, how often have you been bothered by the following?	0 – Not at All	1 – Several Days	2 – More than Half	3 – 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	☐	☐	☐	☐

Total Score: _____ / 21	**Severity:** ☐ Minimal (0–4) ☐ Mild (5–9) ☐ Moderate (10–14) ☐ Severe (15–21)

FUNCTIONAL IMPAIRMENT

☐ Not Difficult	☐ Somewhat Difficult	☐ Very Difficult	☐ Extremely Difficult

Client Name: _____	**Date:** _____	**Clinician:** _____

Scoring Guide: 0–4 = Minimal | 5–9 = Mild | 10–14 = Moderate | 15–21 = Severe Anxiety