GAD-7 SCORING INSTRUCTIONS

Sixteenth Street COMMUNITY HEALTH CENTERS

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	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____ = ____ + ____ + ____)

SCORING INSTRUCTIONS

- Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively
  - 0–4: minimal anxiety
  - 5–9: mild anxiety
  - 10–14: moderate anxiety
  - 15–21: severe anxiety
- When used as a screening tool, further evaluation is recommended when the score is 10 or greater

GAD-7

Durante las <u>últimas 2 semanas</u>, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas? *(Marque con un " " para indicar su respuesta)*	**Ningún día**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Se ha sentido nervioso(a), ansioso(a) o con los nervios de punta	0	1	2	3
2. No ha sido capaz de parar o controlar su preocupación	0	1	2	3
3. Se ha preocupado demasiado por motivos diferentes	0	1	2	3
4. Ha tenido dificultad para relajarse	0	1	2	3
5. Se ha sentido tan inquieto(a) que no ha podido quedarse quieto(a)	0	1	2	3
6. Se ha molestado o irritado fácilmente	0	1	2	3
7. Ha tenido miedo de que algo terrible fuera a pasar	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)