**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Anxiety Disorder**

**Please Circle Your Best Answer**

**Over the last 2 weeks, how often have you been bothered by the following problems?**

**Not at all = 0 Several Days= 1 More than half the days= 2 Nearly every day=3**

**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**

**Total Score: = \_\_\_\_\_\_\_**

**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 at all \_\_ Somewhat difficult\_\_**

**Very difficult\_\_\_ Extremely Difficult\_\_\_**