GAD 7 and PHQ 9 Assessment

GAD 7 Over the **last 2 weeks** how often have you been bothered by any of the following problems?	not at all	several days	more than half the days	nearly every day
Worrying too much about different things	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Trouble relaxing	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Feeling nervous, anxious or on edge	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3
GAD-7 total score =				

GAD-7 Anxiety Severity: Scores represent: 0-5 mild 6-10 moderate
11-15 moderately severe anxiety 15-21 severe anxiety.

PHQ-9 Over the **last 2 weeks** period) how often have you been bothered by any of the following problems?		not at all	several days	more than half the days	nearly every day
1.	Feeling tired or having little energy	0	1	2	3
2.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
3.	Poor appetite or overeating	0	1	2	3
4.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
5.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
6.	Feeling down, depressed, or hopeless	0	1	2	3
7.	Little interest or pleasure in doing things	0	1	2	3
8.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	PHQ9 total score: =				

PHQ-9 Depression Severity: Scores represent: 0-5 = mild 6-10 = moderate
11-15 = moderately severe 16-20 = severe depression