Anxiety Form

Name: ____________ Filled by: ____________ Date: ____________ Code: ____________

Birthdate: ____________ Age: ______ Mail: ____________

To be able to help in the best possible way, please take the necessary time to fill out this questionnaire in the most accurate way possible. Of course, all details will be kept strictly confidential.

Questionnaire GAD 7 to assess the level of anxiety

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