

Name: _____
 Date: _____

GAD-7 Anxiety

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? <i>(Use "✓" to indicate your answer"</i>	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

Column totals: + + +
 = **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 difficult at all <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
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PHQ-9 Depression

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

(Use “✓” to indicate your answer”

	Not all	at Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.....	0	1	2	3
2. Feeling down, depressed, or hopeless.....	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.....	0	1	2	3
4. Feeling tired or having little energy.....	0	1	2	3
5. Poor appetite or overeating.....	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.....	0	1	2	3
8. 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
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	0	1	2	3

Column totals _____ + _____ + _____ + _____

= Total Score _____

Scoring notes.

- **PHQ-9 Depression Severity**

Scores represent: **0-5 = mild 6-10 = moderate 11-15 = moderately severe 16-20 = severe depression**

- **GAD-7 Anxiety Severity.**

This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of “not at all,” “several days,” “more than half the days,” and “nearly every day,” respectively. GAD-7 total score for the seven items ranges from 0 to 21.

Scores represent: **0-5 mild 6-10 moderate 11-15 moderately severe anxiety 15-21 severe anxiety.**

- **Core-10**

Key points in the scoring of the CORE-10 are as follows:

1. Each item within the CORE-10 is scored on a 5-point scale ranging from 0 ('not at all') to 4 ('most or all the time').
2. The clinical score is calculated by adding the response values of all 10 items.
3. Where there are missing data the clinical score is derived by calculating the total mean score (dividing the total score by the number of completed items) and multiplying by 10.
4. We do not recommend re-scaling the clinical score if more than one item is missing.
5. The minimum score that can be achieved is 0 and the maximum is 40.
6. The measure is problem scored, that is, the higher the score the more problems the individual is reporting and/or the more distressed they are.

A score of 10 or below denotes a score within the non-clinical range and of 11 or above within the clinical range. Within the non-clinical range we have identified two bands called 'healthy' and 'low' level distress. People may score on a number of items at any particular time but still remain 'healthy'. Similarly, people may score in the 'low' range which might be a result of raised pressures or particular circumstances but which is still within a non-clinical range. **Within the clinical range we have identified the score of 11 as the lower boundary of the 'mild' level, 15 for the 'moderate' level, and 20 for the 'moderate-to-severe' level. A score of 25 or over marks the 'severe' level.**