

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

Feeling nervous, anxious, or on edge

|                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Not at all               | Several days             | More than half the days  | Nearly every day         |

Not being able to stop or control worrying

|                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Not at all               | Several days             | More than half the days  | Nearly every day         |

Worrying too much about different things

|                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Not at all               | Several days             | More than half the days  | Nearly every day         |

Trouble relaxing

|                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Not at all               | Several days             | More than half the days  | Nearly every day         |

Being so restless that it's hard to sit still

|                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Not at all               | Several days             | More than half the days  | Nearly every day         |

Becoming easily annoyed or irritable

|                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Not at all               | Several days             | More than half the days  | Nearly every day         |

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

|                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Not at all               | Several days             | More than half the days  | Nearly every day         |



Note: This form is for **demonstration purposes** only.

For more information on utilizing this form for clinical use, [sign up here](#) or [contact us](#) to see how we can help