

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Generalized Anxiety Disorder Questionnaire – IV (GADQ-IV)

1. Do you experience excessive worry? Yes \_\_\_\_ No \_\_\_\_
2. Is your worry excessive in intensity, frequency or amount of distress it causes?  
Yes \_\_\_\_ No \_\_\_\_
3. Do you find it difficult to control your worry (or stop worrying) once it starts?  
Yes \_\_\_\_ No \_\_\_\_
4. Do you worry excessively or uncontrollably about minor things such as being late for an appointment, minor repairs, homework, etc.? Yes \_\_\_\_ No \_\_\_\_
5. Please list the most frequent topics about which you worry excessively or uncontrollably:  
a. \_\_\_\_\_ d. \_\_\_\_\_  
b. \_\_\_\_\_ e. \_\_\_\_\_  
c. \_\_\_\_\_ f. \_\_\_\_\_
6. During the last six months, have you been bothered by excessive worries more days than not? Yes \_\_\_\_ No \_\_\_\_
7. During the past six months, have you often been bothered by any of the following symptoms? Place a check next to each symptom that you have more days than not:  

____ restlessness or feeling keyed up or on edge	____ irritability
____ difficulty falling/staying asleep or restless/ unsatisfying sleep	____ being easily fatigued
____ difficulty concentrating or mind going blank	____ muscle tension
8. How much do worry and physical symptoms interfere with your life, work, social activities, family, etc.? Circle one number:  

0	1	2	3	4	5	6	7	8
/	/	/	/	/	/	/	/	/
None		Mild		Moderate		Severe		Very Severe
9. How much are you bothered by worry and physical symptoms (how much distress does it cause you?) Circle one number:  

0	1	2	3	4	5	6	7	8
/	/	/	/	/	/	/	/	/
None		Mild		Moderate		Severe		Very Severe