

# Anxiety Nursing Diagnosis

<b>Patient information</b>					
Patient name:					
Age:					
Gender:					
Date of evaluation:					
<b>Medical history</b>					
Relevant medical conditions:					
Current medications:					
<b>GAD-7 assessment</b>					
#	Question	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1	Feeling nervous, anxious, or on edge				
2	Not being able to stop or control worrying				
3	Worrying too much about different things				
4	Trouble relaxing				
5	Being so restless that it is hard to sit still				
6	Becoming easily annoyed or irritable				
7	Feeling afraid as if something awful might happen				
<b>Total</b>					
<b>Interpretation</b>					
0-4: Minimal anxiety					
5-9: Mild anxiety					
10-14: Moderate anxiety					
15-21: Severe anxiety					

**Observations**

**Preliminary diagnosis**

**Recommendations**

Doctor's name:

Doctor's signature:

Date: