Patient Screening Questions for Supportive Care

All patients are asked to complete this questionnaire as part of their standard of care.
Please take a few minutes to answer the following questions to help us better address your needs.

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Over the **last 14 days,** how often have you been bothered by the following problems? [1]	Not at all	Several Days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	❑	❑	❑	❑
Not being able to stop or control worrying	❑	❑	❑	❑
Little interest or pleasure in doing things	❑	❑	❑	❑
Feeling down, depressed, or hopeless	❑	❑	❑	❑

	YES	NO [11]
Do you need someone like a family member, friend, hospital/clinic worker, or caregiver to help you read hospital materials?	❑	❑
Do you need help when filing out medical forms by yourself?	❑	❑

Indicate if any of the below has been a concern for you in the **past 7 days,** please check YES or NO for each.

Practical Concerns [2, 9]

YES	NO	
❑	❑	Child care issues
❑	❑	Issues paying for food
❑	❑	Issues paying for housing
❑	❑	Issues with transportation to/from treatment
❑	❑	Work / school issues
❑	❑	Insurance coverage issues or no health insurance
❑	❑	Paying for medication or medical care
❑	❑	I live alone

Self Care Concerns [10]

Are you concerned about having someone available to help if:

YES	NO	
❑	❑	You cannot get out of bed?
❑	❑	You feel sick and cannot do daily chores?
❑	❑	You cannot run errands?

Family/Caregiver Concerns [2]

YES	NO	
❑	❑	Concerns about my children
❑	❑	Concerns about my partner
❑	❑	Concerns about caregivers
❑	❑	Ability to have children
❑	❑	Concerns about other family members

Spiritual / Faith / Religious Concerns [5]

YES	NO	
❑	❑	Do you struggle with the loss of meaning and joy in your life?
❑	❑	Do you have religious or spiritual struggles?

I would like to talk to someone about my "yes" checks above from Practical, Self Care, Family/Caregiver or Spiritual Concerns
YES❑ NO❑

Physical and Other Concerns [2]

YES	NO	
❑	❑	Breathing
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Fevers
❑	❑	Nausea or vomiting
❑	❑	Sleep
❑	❑	Changes in urination
❑	❑	Difficulty chewing or swallowing
❑	❑	Cough
❑	❑	Mouth sores
❑	❑	Dry mouth
❑	❑	Swollen arms or legs
❑	❑	Feeling full quickly or swollen abdomen
❑	❑	Sexual intimacy or function
❑	❑	Skin dry/itchy, blister/pain
❑	❑	Tingling in hands/feet
❑	❑	Appearance
❑	❑	Use of alcohol/drugs
❑	❑	Difficulty concentrating
❑	❑	Difficulty remembering things
❑	❑	Difficulty finding the words I want to say

Nutrition Concerns [2, 3]

YES	NO	
❑	❑	Weight loss or lack of appetite
❑	❑	Weight gain
❑	❑	Issues with taste
❑	❑	Concerns about nutrition and food

See other side to complete

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Please answer these questions to help us address what you need.
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Pain[6] In the past 7 days, have you been in pain?

❑ **NO** If NO, *skip to* **"Fatigue/Low Energy"**

❑ **YES** If YES, *please mark one box per row below*

	No pain	Mild	Moderate	Severe	Very Severe
In the past 7 days how intense was your pain at its worst?	❑	❑	❑	❑	❑
In the past 7 days how intense was your average pain?	❑	❑	❑	❑	❑
What is your level of pain right now?	❑	❑	❑	❑	❑

Fatigue/Low Energy [7] *Please mark one box per row*

	Not at all	A little bit	Somewhat	Quite a bit	Very much
During the past 7 days I feel fatigued (low energy)	❑	❑	❑	❑	❑
During the past 7 days I have trouble starting things because I am tired	❑	❑	❑	❑	❑
In the past 7 days how run-down did you feel on average?	❑	❑	❑	❑	❑
In the past 7 days how fatigued were you on average?	❑	❑	❑	❑	❑

Physical Activity [8] *Please mark one box per row*

	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
Are you able to do chores such as vacuuming or yard work?	❑	❑	❑	❑	❑
Are you able to go up and down stairs at a normal pace?	❑	❑	❑	❑	❑
Are you able to run errands and shop?	❑	❑	❑	❑	❑
Are you able to be out of bed most of the day?	❑	❑	❑	❑	❑
Are you able to take care of your personal needs (dress, comb hair, toilet, eat, bathe)?	❑	❑	❑	❑	❑

Falls

	YES	NO
Have you had 2 or more falls in the past 6 months? [1]	❑	❑
Have you been injured by a fall that required medical attention in the last 6 months?	❑	❑
Do you feel unsteady when walking? [12]	❑	❑

Treatment or Care Concerns [4] *Please please check Yes or No for each*

YES	NO	
❑	❑	I want to better understand my cancer diagnosis or stage.
❑	❑	I want to better understand my prognosis or long term outcome.
❑	❑	I have concerns or questions about my treatment options, medication, or my plan of care.
❑	❑	I want help discussing, with my family and friends, my treatment options and what is important to me.
❑	❑	I want help discussing and deciding on the kinds of medical care I want or don't want with my family, friends or doctor

Other problems or concerns [2]:

Office Use Only:
Pt alone ❑
Pt with family ❑
Pt with clinician/staff ❑

***This tool is adapted from:** (1) the PHQ-4 developed by Drs. Robert L. Spitzer, Janet B.W. Wiliams, Kurt Kroenke and colleagues; (2) The National Comprehensive Cancer Network, NCCN Guidelines version 2.2014 Distress Management; (3) Kaiser, M.J., et al., Validation of the Mini Nutritional Assessment short-form (MNA-SF): a practical tool for identification of nutritional status. J Nutr Health Aging, 2009. 13(9): p. 782-8.; (4) Living Well Cancer Resource Center Distress Tool. (5) King, S. D. W., et al. (2017). Determining best methods to screen for religious/spiritual distress. Support Care Cancer (2017) 25:471–479. (6) PROMIS Item Bank v1.0 Pain Intensity Short Form 3a; (7) PROMIS Item Bank v1.0 Fatigue Short Form 4a; (8) PROMIS Item Bank v1.0 Physical Function Short Form 4a; and PROMIS item bank. (9) Live Well At Home Rapid Screen©. (10) PROMIS Item Bank Instrumental Support – Short Form 4a. (11) Cornett, S., (Sept. 30, 2009) "Assessing and Addressing Health Literacy" OJIN: The Online Journal of Issues in NursingVol. 14, No. 3, Manuscript 2. (12) Phelan, E. A., Mahoney, J. E., Voit, J. C., & Stevens, J. A. (2015). Assessment and Management of Fall Risk in Primary Care Settings. *The Medical Clinics of North America*, *99*(2), 281–293. http://doi.org/10.1016/j.mcna.2014.11.004