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.

### Over the last 14 days, how often have you been bothered by the following problems?  

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling nervous, anxious or on edge</td>
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<tr>
<td>Not being able to stop or control worrying</td>
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<tr>
<td>Little interest or pleasure in doing things</td>
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<tr>
<td>Feeling down, depressed, or hopeless</td>
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</tbody>
</table>

**YES**  
**NO**

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?

**YES**  
**NO**

### 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

**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

**YES**  
**NO**

- [ ] You cannot get out of bed?
- [ ] You feel sick and cannot do daily chores?
- [ ] You cannot run errands?

#### Family/Caregiver Concerns

**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

**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

**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

**YES**  
**NO**

- [ ] Weight loss or lack of appetite
- [ ] Weight gain
- [ ] Issues with taste
- [ ] Concerns about nutrition and food

**See other side to complete**
Please answer these questions to help us address what you need.
(continued page 2 of 2)

### Pain
- 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

<table>
<thead>
<tr>
<th></th>
<th>No pain</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the past 7 days how intense was your pain at its worst?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>In the past 7 days how intense was your average pain?</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is your level of pain right now?</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Fatigue/Low Energy
- Please mark one box per row

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

### Physical Activity
- Please mark one box per row

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

### Falls
- Have you had 2 or more falls in the past 6 months?  
- Have you been injured by a fall that required medical attention in the last 6 months?
- Do you feel unsteady when walking?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you had 2 or more falls in the past 6 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been injured by a fall that required medical attention in the last 6 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel unsteady when walking?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Treatment or Care Concerns
- Please please check Yes or No for each

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>I want to better understand my cancer diagnosis or stage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I want to better understand my prognosis or long term outcome.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have concerns or questions about my treatment options, medication, or my plan of care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I want help discussing, with my family and friends, my treatment options and what is important to me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I want help discussing and deciding on the kinds of medical care I want or don’t want with my family, friends or doctor</td>
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<td></td>
</tr>
</tbody>
</table>

### Other problems or concerns:

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

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