Identifying your concerns

Discussed by:

Date:

Designation:

Contact details:

Patient's name or label

This self assessment is optional, however it will help us understand the concerns and feelings you have. It will also help us identify any information and support you may need in the future.

If any of the problems below have caused you concern in the past week and if you wish to discuss them with a health care professional, please tick the box. Leave the box blank if it doesn't apply to you or you don't want to discuss it now.

☐ I have questions about my diagnosis/treatment that I would like to discuss.

Physical concerns

☐ Breathing difficulties
☐ Passing urine
☐ Constipation
☐ Diarrhoea
☐ Eating or appetite
☐ Indigestion
☐ Sore or dry mouth
☐ Nausea or vomiting
☐ Sleep problems/nightmares
☐ Tired/exhausted or fatigued
☐ Swollen tummy or limb
☐ High temperature or fever
☐ Getting around (walking)
☐ Tingling in hands/feet
☐ Pain
☐ Hot flushes/sweating
☐ Dry, itchy or sore skin
☐ Wound care after surgery
☐ Changes in weight
☐ Memory or concentration
☐ Taste/sight/hearing
☐ Speech problems
☐ My appearance
☐ Sex/intimacy/fertility

Practical concerns

☐ Caring responsibilities
☐ Work and education
☐ Money or housing
☐ Insurance and travel
☐ Transport or parking
☐ Contact/communication with NHS staff
☐ Laundry/housework
☐ Washing and dressing
☐ Preparing meals/drinks
☐ Grocery shopping

Family/relationship concerns

☐ Partner
☐ Children
☐ Other relatives/friends

Emotional concerns

☐ Difficulty making plans
☐ Loss of interest/activities
☐ Unable to express feelings
☐ Anger or frustration
☐ Guilt
☐ Hopelessness
☐ Loneliness or isolation
☐ Sadness or depression
☐ Worry, fear or anxiety

Spiritual or religious concerns

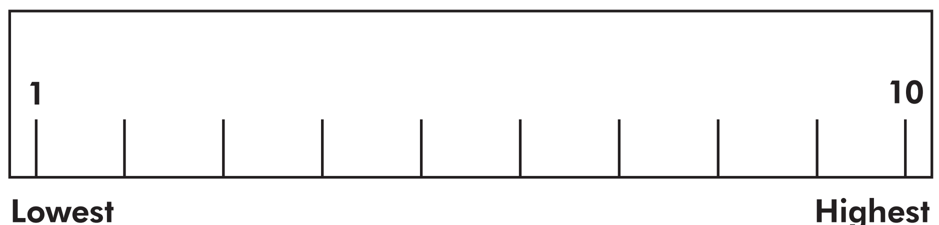
☐ Loss of faith or other spiritual concerns
☐ Loss of meaning or purpose of life
☐ Not being at peace with or feeling regret about the past

Lifestyle or information needs

☐ Support groups
☐ Complementary therapies
☐ Diet and nutrition
☐ Exercise and activity
☐ Smoking
☐ Alcohol or drugs
☐ Sun protection
☐ Hobbies
☐ Staying in returning to work and education
☐ Making a will
☐ Other

Please mark the scale to show the overall level of concern you've felt over the past week.

You may also wish to score the concerns you have ticked from 1 to 10.



Lowest **Highest**

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