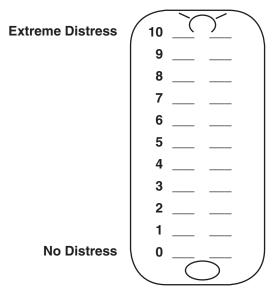
We care about you. Tell us how you are feeling.

Name: ___

Date of Birth:

Today's Date:

Instructions: Please circle the number (0-10) that best describes how much stress you have been experiencing in the past week including today.



Please indicate if any of the following has been a problem for you in the past week, including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems
		Child Care
		Housing
		Insurance/financial
		Transportation
		Work/School
		Treatment decisions
YES	NO	Family Problems
		Dealing with children
		Dealing with partner
		Ability to have children
		Family health issues

Please do not write below this line:

□ Referred to oncology social worker

YES	№	Emotional Problems Depression Fears Nervousness Sadness Worry Loss of interest in usual activities Feelings of abandonment Spiritual/Religious Concerns
	200000000000000000000000000000000000000	Physical Problems Appearance Bathing/dressing Breathing Changes in urination Constipation Diarrhea Eating Fatigue Feeling swollen Fevers Getting around Indigestion Memory/concentration Mouth sores Nausea Nose dry/congested Pain
		Sexual Skin dry/itchy Sleep Substance Abuse Tingling in hands/feet

Other problems: _____

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