

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.

Extreme Distress	10	<input type="checkbox"/>	<input type="checkbox"/>
	9	<input type="checkbox"/>	<input type="checkbox"/>
	8	<input type="checkbox"/>	<input type="checkbox"/>
	7	<input type="checkbox"/>	<input type="checkbox"/>
	6	<input type="checkbox"/>	<input type="checkbox"/>
	5	<input type="checkbox"/>	<input type="checkbox"/>
	4	<input type="checkbox"/>	<input type="checkbox"/>
	3	<input type="checkbox"/>	<input type="checkbox"/>
	2	<input type="checkbox"/>	<input type="checkbox"/>
	1	<input type="checkbox"/>	<input type="checkbox"/>
No Distress	0	<input type="checkbox"/>	<input type="checkbox"/>

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
<input type="checkbox"/>	<input type="checkbox"/>	Child Care
<input type="checkbox"/>	<input type="checkbox"/>	Housing
<input type="checkbox"/>	<input type="checkbox"/>	Insurance/financial
<input type="checkbox"/>	<input type="checkbox"/>	Transportation
<input type="checkbox"/>	<input type="checkbox"/>	Work/School
<input type="checkbox"/>	<input type="checkbox"/>	Treatment decisions

YES	NO	Family Problems
<input type="checkbox"/>	<input type="checkbox"/>	Dealing with children
<input type="checkbox"/>	<input type="checkbox"/>	Dealing with partner
<input type="checkbox"/>	<input type="checkbox"/>	Ability to have children
<input type="checkbox"/>	<input type="checkbox"/>	Family health issues

Please do not write below this line: _____

Referred to oncology social worker

YES	NO	Emotional Problems
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Fears
<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	Sadness
<input type="checkbox"/>	<input type="checkbox"/>	Worry
<input type="checkbox"/>	<input type="checkbox"/>	Loss of interest in usual activities
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of abandonment
<input type="checkbox"/>	<input type="checkbox"/>	Spiritual/Religious Concerns

YES	NO	Physical Problems
<input type="checkbox"/>	<input type="checkbox"/>	Appearance
<input type="checkbox"/>	<input type="checkbox"/>	Bathing/dressing
<input type="checkbox"/>	<input type="checkbox"/>	Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Changes in urination
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Eating
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Feeling swollen
<input type="checkbox"/>	<input type="checkbox"/>	Fevers
<input type="checkbox"/>	<input type="checkbox"/>	Getting around
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Memory/concentration
<input type="checkbox"/>	<input type="checkbox"/>	Mouth sores
<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Nose dry/congested
<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Sexual
<input type="checkbox"/>	<input type="checkbox"/>	Skin dry/itchy
<input type="checkbox"/>	<input type="checkbox"/>	Sleep
<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Tingling in hands/feet

Other problems: _____

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