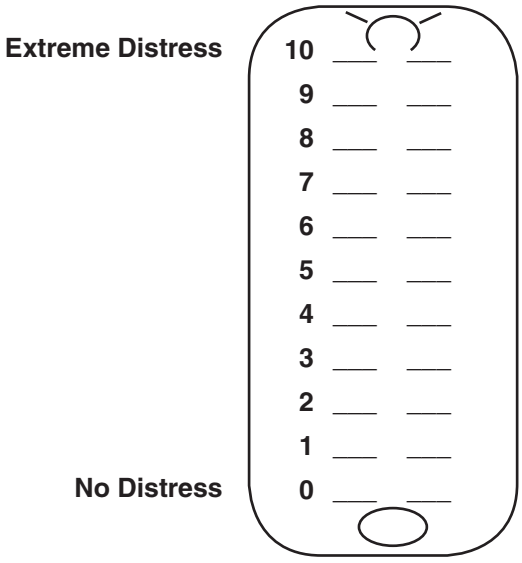
We care about you.
Tell us how you are feeling.

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	NO	Emotional Problems
☐	☐	Depression
☐	☐	Fears
☐	☐	Nervousness
☐	☐	Sadness
☐	☐	Worry
☐	☐	Loss of interest in usual activities
☐	☐	Feelings of abandonment
☐	☐	**Spiritual/Religious Concerns**

YES	NO	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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