Concerns Checklist – identifying your concerns

Patient's name or label

Key worker: _____

Date: _____

Contact number: _____

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.

Below is a list of symptoms which you may or may not have experienced. Please select **one box for each of these**, to describe how it has affected you **over the last few days**

Physical symptoms

Please circle one box.	Not at all	Slightly	Moderately	Severely	Overwhelmingly
Pain	0	1	2	3	4
Shortness of breath	0	1	2	3	4
Weakness or lack of energy	0	1	2	3	4
Nausea (feeling like you are going to be sick)	0	1	2	3	4
Vomiting (being sick)	0	1	2	3	4
Poor appetite	0	1	2	3	4
Constipation	0	1	2	3	4
Sore or dry mouth	0	1	2	3	4
Drowsiness	0	1	2	3	4
Poor mobility	0	1	2	3	4

Physical concerns

Below is a list of symptoms which you may or may not have experienced. If **any of these** have been a concern for you **over the last few days**, **please circle one box** to describe how they have affected you.	Not at all	Slightly	Moderately	Severely	Overwhelmingly
Passing urine	0	1	2	3	4
Diarrhoea	0	1	2	3	4
Indigestion	0	1	2	3	4
Swallowing	0	1	2	3	4
Cough	0	1	2	3	4
Swelling	0	1	2	3	4
High temperature or fever	0	1	2	3	4
Tingling in hands or feet	0	1	2	3	4
Hot flushes or sweating	0	1	2	3	4
Dry, itchy or sore skin	0	1	2	3	4
Changes in weight	0	1	2	3	4
Wound care	0	1	2	3	4
Memory or concentration	0	1	2	3	4
Sight or hearing	0	1	2	3	4
Speech or voice problems	0	1	2	3	4
My appearance	0	1	2	3	4
Sleep problem	0	1	2	3	4
Sex, intimacy, or fertility	0	1	2	3	4
Other medical condition	0	1	2	3	4

Practical concerns

Below is a list of symptoms which you may or may not have experienced. If **any of these** have been a concern for you **over the last few days**, **please circle one box** to describe how they have affected you.	Not at all	Slightly	Moderately	Severely	Overwhelmingly
Taking care of others	0	1	2	3	4
Work or education	0	1	2	3	4
Money or finance	0	1	2	3	4
Travel	0	1	2	3	4
Housing	0	1	2	3	4
Transport or parking	0	1	2	3	4
Talking or being understood	0	1	2	3	4
Laundry or housework	0	1	2	3	4
Grocery shopping	0	1	2	3	4
Washing and dressing	0	1	2	3	4
Preparing meals or drinks	0	1	2	3	4
Pets	0	1	2	3	4
Difficulty making plans	0	1	2	3	4
Smoking cessation	0	1	2	3	4
Problems with alcohol or drugs	0	1	2	3	4
My medication	0	1	2	3	4

Emotional concerns

Below is a list of symptoms which you may or may not have experienced. If **any of these** have been a concern for you **over the last few days**, **please circle one box** to describe how they have affected you.	Not at all	Slightly	Moderately	Severely	Overwhelmingly
Uncertainty	0	1	2	3	4
Loss of interest in activities	0	1	2	3	4
Unable to express feelings	0	1	2	3	4
Thinking about the future	0	1	2	3	4
Regret about the past	0	1	2	3	4
Anger or frustration	0	1	2	3	4
Loneliness	0	1	2	3	4
Sadness or depression	0	1	2	3	4
Hopelessness	0	1	2	3	4
Guilt	0	1	2	3	4
Worry, fear, or anxiety	0	1	2	3	4
Independence	0	1	2	3	4

Family Concerns

Below is a list of symptoms which you may or may not have experienced. If **any of these** have been a concern for you **over the last few days**, **please circle one box** to describe how they have affected you.	Not at all	Slightly	Moderately	Severely	Overwhelmingly
Partner	0	1	2	3	4
Children	0	1	2	3	4
Other relatives or friends	0	1	2	3	4
Person who looks after me	0	1	2	3	4
Person who I look after	0	1	2	3	4

Spiritual or religious concerns

Below is a list of symptoms which you may or may not have experienced. If **any of these** have been a concern for you **over the last few days**, **please circle one box** to describe how they have affected you.	Not at all	Slightly	Moderately	Severely	Overwhelmingly
Faith or spirituality	0	1	2	3	4
Meaning or purpose of life	0	1	2	3	4
Feeling at odd with culture, beliefs, or values	0	1	2	3	4

Additional Questions

Please select which best describes how it has been **over the last few days** by circle one box	Not at all	Occasionally	Sometimes	Most of the time	Always
Have you been feeling anxious or worried about your illness or treatment?	0	1	2	3	4
Have any of your family or friends been anxious or worried about you?	0	1	2	3	4
Have you been feeling depressed?	0	1	2	3	4
Have you felt at peace?	0	1	2	3	4
Have you been able to share how you are feeling with your family or friends as much as you wanted?	0	1	2	3	4
Have you had as much information as you wanted?	0	1	2	3	4

	Addressed/no Problems	Mostly Addressed	Partly addressed	Hardly addressed	Not addressed
How well have any practical problems (financial or personal) resulting from your illness been addressed?	0	1	2	3	4

	Not my own	With help from a friend or relative	With help from a member of staff
How did you complete this questionnaire?	0	1	2

☐ I have questions about my diagnosis, treatments, or effects

Key worker to complete ☐ Copy given to patient ☐ Copy to be sent to GP

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