



Holistic Assessment

Name/NHSNumber:	
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If you would like to discuss any of these concerns, please tick the box and scale your distress level <input type="checkbox"/> I have questions about my diagnosis/treatment that I would like to discuss
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Discussed with	Date
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0 = No Distress 10 = Extreme Distress

Practical Concerns Distress level: <input type="checkbox"/>	<input type="checkbox"/> Caring Responsibilities <input type="checkbox"/> Preparing Meals/Drinks <input type="checkbox"/> Grocery Shopping <input type="checkbox"/> Talking or being Understood <input type="checkbox"/> Smoking Cessation <input type="checkbox"/> My Medication	<input type="checkbox"/> Washing and Dressing <input type="checkbox"/> Transport or Parking <input type="checkbox"/> Money or Finance <input type="checkbox"/> Taking Care of Others <input type="checkbox"/> Pets <input type="checkbox"/> Difficulty Making Plans	<input type="checkbox"/> Travel <input type="checkbox"/> Work or Education <input type="checkbox"/> Laundry or Housework <input type="checkbox"/> Housing <input type="checkbox"/> Problems with Alcohol or Drugs
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Family/ Relationship Concerns Distress level: <input type="checkbox"/>	<input type="checkbox"/> Children <input type="checkbox"/> Person who looks after me	<input type="checkbox"/> Partner <input type="checkbox"/> Person who I look after	<input type="checkbox"/> Other Relative or Friend
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Emotional Concerns Distress level: <input type="checkbox"/>	<input type="checkbox"/> Anger or Frustration <input type="checkbox"/> Worry, Fear or Anxiety <input type="checkbox"/> Unable to Express Feelings <input type="checkbox"/> Independence	<input type="checkbox"/> Guilt <input type="checkbox"/> Loss of Interest/Activities <input type="checkbox"/> Sadness or Depression <input type="checkbox"/> Thinking about the future	<input type="checkbox"/> Loneliness or Isolation <input type="checkbox"/> Hopelessness <input type="checkbox"/> Uncertainty <input type="checkbox"/> Regret about the past
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Spiritual Concerns Distress level: <input type="checkbox"/>	<input type="checkbox"/> Faith or Spirituality	<input type="checkbox"/> Not being at Peace or Feeling Regret about the Past	<input type="checkbox"/> Meaning or purpose of life
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Physical Concerns Distress level: <input type="checkbox"/>	<input type="checkbox"/> My Appearance <input type="checkbox"/> Constipation <input type="checkbox"/> Tired/Exhausted or Fatigued <input type="checkbox"/> Hot Flashes/Sweating <input type="checkbox"/> Memory or Concentration <input type="checkbox"/> Pain or discomfort <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Wound Care <input type="checkbox"/> Swallowing	<input type="checkbox"/> Breathing Difficulties <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Swelling <input type="checkbox"/> Moving Around (Walking) <input type="checkbox"/> Sore or Dry Mouth or Ulcers <input type="checkbox"/> Sex/Intimacy/Fertility <input type="checkbox"/> Speech or Voice Problems <input type="checkbox"/> Changes in Weight <input type="checkbox"/> Cough	<input type="checkbox"/> Passing Urine <input type="checkbox"/> Eating, Appetite or Taste <input type="checkbox"/> High Temperature or Fever <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea or Vomiting <input type="checkbox"/> Dry, Itchy or Sore Skin <input type="checkbox"/> Tingling in Hands/Feet <input type="checkbox"/> Sight or Hearing <input type="checkbox"/> Other Medical Conditions
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Information or Support Distress level: <input type="checkbox"/>	<input type="checkbox"/> Complementary Therapies <input type="checkbox"/> Sun Protection <input type="checkbox"/> Managing my symptoms	<input type="checkbox"/> Diet and Nutrition <input type="checkbox"/> Making a will or legal advice <input type="checkbox"/> Patient or carer's support groups	<input type="checkbox"/> Exercise and Activity <input type="checkbox"/> Planning for my future priorities <input type="checkbox"/> Health and Wellbeing
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Other Concerns	
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Additional Comments	
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