Concerns Checklist – identifying your concerns

Patient’s name or label

Key worker: ____________________________

Date: ________________________________

Contact number: ______________________

This self assessment is optional. It has been designed to help us support you by identifying any concerns you may have and information you may require.

What do I need to do?

Select any areas that may have caused you concern recently and you would like to discuss with your key worker.

When selecting please score each concern between 1-10, with 1 being low level of concern and 10 the highest.

Physical concerns

☐ Breathing difficulties
☐ Passing urine
☐ Constipation
☐ Diarrhoea
☐ Eating, appetite or taste
☐ Indigestion
☐ Swallowing
☐ Cough
☐ Sore or dry mouth or ulcers
☐ Nausea or vomiting
☐ Tired, exhausted or fatigued
☐ Swelling
☐ High temperature or fever
☐ Moving around (walking)
☐ Tingling in hands or feet
☐ Pain or discomfort
☐ Hot flushes or sweating
☐ Dry, itchy or sore skin
☐ Changes in weight
☐ Wound care
☐ Memory or concentration
☐ Sight or hearing
☐ Speech or voice problems
☐ My appearance
☐ Sleep problems
☐ Sex, intimacy or fertility
☐ Other medical conditions

Practical concerns

☐ Taking care of others
☐ Work or education
☐ Money or finance
☐ Travel
☐ Housing
☐ Transport or parking
☐ Talking or being understood
☐ Laundry or housework
☐ Grocery shopping
☐ Washing and dressing
☐ Preparing meals or drinks
☐ Pets
☐ Difficulty making plans
☐ Smoking cessation
☐ Problems with alcohol or drugs
☐ My medication

Emotional concerns

☐ Uncertainty
☐ Loss of interest in activities
☐ Unable to express feelings
☐ Thinking about the future
☐ Regret about the past
☐ Anger or frustration
☐ Loneliness or isolation
☐ Sadness or depression
☐ Hopelessness
☐ Guilt

☐ Worry, fear or anxiety
☐ Independence

Family or relationship concerns

☐ Partner
☐ Children
☐ Other relatives or friends
☐ Person who looks after me
☐ Person who I look after

Spiritual concerns

☐ Faith or spirituality
☐ Meaning or purpose of life
☐ Feeling at odds with my culture, beliefs or values

Information or support

☐ Exercise and activity
☐ Diet and nutrition
☐ Complementary therapies
☐ Planning for my future priorities
☐ Making a will or legal advice
☐ Health and wellbeing
☐ Patient or carer’s support group
☐ Managing my symptoms
☐ Sun protection

☐ I have questions about my diagnosis, treatments or effects

Key worker to complete: ________________________

Copy given to patient: ________________________

Copy to be sent to GP: ________________________