FOUNDATION HEALTH PARTNERS
J. MICHAEL CARROLL CANCER CENTER

Patient Label

CANCER CARE DISTRESS THERMOMETER

Printed Name: _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____

Please indicate if any of the following has been a problem for you in the past week (including today). Please be sure to check YES or NO for each.

YES	NO	Practical Problems
☐	☐	Child care
☐	☐	Housing
☐	☐	Insurance / financial
☐	☐	Transportation
☐	☐	Work / school
☐	☐	Treatment decisions
		Family Problems
☐	☐	Dealing with children
☐	☐	Dealing with partner
☐	☐	Ability to have children
☐	☐	Family health issues
		Emotional Problems
☐	☐	Depression
☐	☐	Fears
☐	☐	Nervousness
☐	☐	Sadness
☐	☐	Worry
☐	☐	Loss of interest in usual activities
☐	☐	**Spiritual / religious concerns**

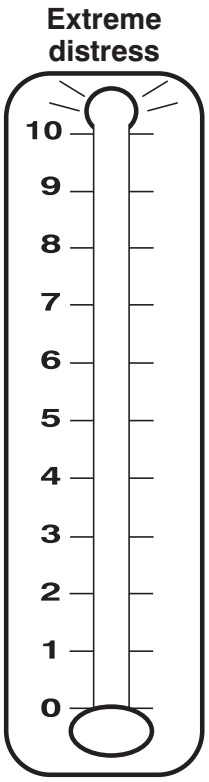
YES	NO	Physical Problems
☐	☐	Appearance
☐	☐	Bathing / dressing
☐	☐	Breathing
☐	☐	Changes in urination
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Eating
☐	☐	Fatigue
☐	☐	Feeling Swollen
☐	☐	Fevers
☐	☐	Getting around
☐	☐	Indigestion
☐	☐	Memory / concentration
☐	☐	Mouth sores
☐	☐	Nausea
☐	☐	Nose dry / congested
☐	☐	Pain
☐	☐	Sexual
☐	☐	Skin dry / itchy
☐	☐	Sleep
☐	☐	Substance abuse
☐	☐	Tingling in hands / feet

Other Problems not listed above:

_____

_____

Please circle the number (0-10) on the thermometer below that BEST describes how much distress you have been experiencing in the past week including today.



To Be Completed by Medical Staff

Primary Diagnosis: _____

Provider Signature: _____ **Date & Time:** _____

Provider Name (printed): _____

6628 Cancer Care