Concerns Checklist – identifying your concerns.

Person'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.

If any of the problems listed have caused you concern recently and you wish to discuss them with a key worker, please score the concern from 1 to 10, with 10 being the highest. Leave the box blank if it doesn't apply to you or you don't want to discuss it now.

Key worker to complete

- ☐ Copy given to individual
- ☐ Copy to be sent to GP

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 plan
- ☐ 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 care support group
- ☐ Managing my symptoms
- ☐ Sun protection

☐ **I have questions about my diagnosis, treatment or effects.**

MACMILLAN CANCER SUPPORT