



Health Assessment Form

Welcome.

Please answer the following questions to help us know about your needs. Your answers will help us develop more individualized programs for you. The information will become part of your health record and will be accessible to the health care staff. **Please feel free to leave any questions blank that you do not wish to answer.**

Date:

Why are you here today?

General Information:

1. Marital Status: Single Married/Common-law/Living with Partner
 Separated/Divorced Widowed
2. Name of Spouse/Partner
3. Do you have children? No Yes If Yes, how many
Age: youngest child _____ oldest child _____
Do you have other dependents? No Yes
4. To which ethnic or cultural group do you belong?
(Check more than one if applicable)
 Aboriginal (eg. North American First Nation, Metis, Inuit)
 Arab/West Asian (eg. Armenian, Iranian, Lebanese, Moroccan)
 Black (eg. African, Haitian, Jamaican, Somali)
 Chinese Filipino
 Japanese Korean
 Latin-American Caucasian, European
 South Asian (eg. East Indian, Pakistani, Sri Lankan)
 South-Eastern Asian (eg. Indonesian, Laotian, Thai, Vietnamese)
 Other, please specify
5. What is your preferred language of communication?
6. Would you like spiritual or religious support? Yes No
If yes, please specify
7. Where do you live?
 Own home Senior Housing Nursing Home Other
8. Do you have additional health coverage? Yes No Don't Know
9. Are you currently working? Yes No
What is/was your usual occupation?
10. Does your spouse/partner work? Yes No
What is/was their usual occupation?

Notes



Nutrition Screening Tool

Nutrition Information:

Please answer the following questions to help us assess your nutritional status.

This information will become part of your health record and will be accessible to health care staff.

1. Weight

I currently weigh about _____ pounds or kilograms.

I am about _____ feet _____ inches or centimeter tall.

One month ago I weighed about _____ pounds or kilograms.

Six months ago I weighed about _____ pounds or kilograms.

During the past two weeks my weight has:

decreased₍₁₎

not changed₍₀₎

increased₍₀₎

2. Food Intake: As compared to my normal, I would rate my food intake during the past month as:

unchanged₍₀₎

more than usual₍₀₎

less than usual₍₁₎

I am now taking:

normal food but less than usual₍₁₎

little solid food₍₂₎

only liquids₍₃₎

only nutritional supplements₍₃₎

very little of anything₍₄₎

only tube feedings₍₀₎

3. Symptoms: The following problems have kept me from eating enough during the past two weeks (check all that apply):

no problems eating₍₀₎

nausea₍₁₎

mouth sores₍₂₎

problems swallowing₍₂₎

feel full quickly₍₁₎

constipation₍₁₎

pain: where? ₍₃₎ _____

Other** ₍₁₎ _____

no appetite, just did not feel like eating₍₃₎

vomiting₍₃₎

things taste funny or have no taste₍₁₎

dry mouth₍₁₎

smells bother me₍₁₎

diarrhea₍₃₎

** examples: depression, money, or dental problems

4. Activities and Function: Over the past month, I would generally rate my activity as:

normal with no limitations₍₀₎

not my normal self, but able to be up and about with fairly normal activities₍₁₎

not feeling up to most things, but in bed or chair less than half the day₍₂₎

able to do little activity and spend most of the day in bed or chair₍₃₎

pretty much bedridden, rarely out of bed₍₃₎

If the Total score is 4 or greater, make a referral to Nutrition Services.

Total Score



PSSCAN PSYCHOLOGICAL SCREENING

Please answer the following questions to help us learn more about your well being. A serious illness can affect the quality of your life in many ways. We may contact you to offer our counselling services based on the information you provide to us, or contact you regarding opportunities to participate in research.

Part A Please respond to each question with a simple “Yes” or “No” by making a circle around the appropriate answer or by circling a number. There are no right and wrong answers.

- | | | |
|--|-------------------------------|--------------|
| 1. Do you live alone? | YES | NO |
| 2. When you need help, can you count on anyone to help with daily tasks like grocery shopping, cooking, giving you a ride? | YES | NO |
| 3. Do you have regular contact with friends or relatives? | YES | NO |
| 4. Have you lost your life partner within the last few years? | YES | NO |
| 5. Can you count on anyone to provide you with emotional support? | YES | NO |
| 6. Do you feel that you <u>want and need</u> this kind of emotional support? | | |
| No, not at all | <u>0 1 2 3 4 5 6 7 8 9 10</u> | Very much so |

Part B: Please circle the number that best describes how you feel:

7. Would you say that in general your health is
- Very Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent
8. Would you say that in general your quality of life is
- Very Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent
9. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? _____ days
10. Now thinking about level of stress, depression, and problems with emotions, for how many days during the past 30 days was your mood not good? _____ days
11. During the past 30 days, for about how many days did poor physical or emotional health keep you from doing your usual activities, such as self-care, work or recreation? _____ days

Please turn over the page

Part C: Please place an 'x' in the box that best describes what you have experienced

	Not at all	A Little Bit	Moderately So	Quite a bit	Very Much so
12. During the past week I have felt that my heart races and I tremble.					
13. During the past week I have felt that I cannot control anything.					
14. During the past week I have lost interest in things I usually cared for or enjoyed.					
15. During the past week I have felt nervous and shaky inside.					
16. During the past week I have felt tense and can't relax.					
17. During the past week my thoughts are repetitive and full of scary things.					
18. During the past week I have felt restless and find it difficult to sit still.					
19. I have <i>recently</i> thought about taking my life. NOTE: If you have thoughts about taking your life, please speak with a member of your health care team and/or your family Doctor immediately.					
20. In the past year , I have had 2 weeks or more during which I felt sad, blue or depressed					
21. I have had 2 years or more in my life when I have felt depressed or sad most days even if I felt o.k. sometimes					

Thank you for taking the time to respond to this form!

If you or your family is currently struggling with the stress of your diagnosis, information and support is available at our website. www.bccancer.bc.ca/PPI/copingwithcancer

Name _____

Date of Birth _____

Telephone _____

BCCA # (if known) _____