



## 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



16. Have you ever smoked or chewed tobacco?

Yes  No

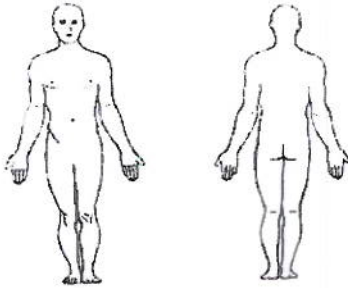
If yes, how many years? \_\_\_\_\_

# cigarettes/cigars/chews per day \_\_\_\_\_

Have you quit?  Yes  No

If yes, how long ago? \_\_\_\_\_ years \_\_\_\_\_ months

17. Do you drink alcoholic beverages?  Yes  No



18. Do you have pain?  Yes  No

Please mark on pictures where you hurt.

Describe your pain:

0 1 2 3 4 5 6 7 8 9 10  
no pain worst pain

What helps make your pain better? \_\_\_\_\_

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19. Are you currently having any of the following symptoms?

- Bleeding  Low appetite  Nausea  Trouble passing urine  
 Chest pain  Diarrhea  Night Sweats  Vomiting  
 Constipation  Headaches  Weight gain  Shortness of breath  
 Cough  Leg swelling  Weight loss  Swallowing difficulties  
 None of the above

20. Please circle the number that best represents your level of fatigue

- (tiredness) 0 usual activity - no problem  
1 mild; able to continue normal activity  
2 change in normal activity (bed rest less than 50% waking hours)  
3 in bed/chair more than 50% waking hours  
4 bed ridden or unable to care for self

21. Are you receiving Homemaking Services?  Yes  No

Are you receiving Home Care Nursing?  Yes  No

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<sub>(1)</sub>       not changed<sub>(0)</sub>       increased<sub>(0)</sub>

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

- unchanged<sub>(0)</sub>  
 more than usual<sub>(0)</sub>  
 less than usual<sub>(1)</sub>

I am now taking:

- normal food but less than usual<sub>(1)</sub>  
 little solid food<sub>(2)</sub>  
 only liquids<sub>(3)</sub>  
 only nutritional supplements<sub>(3)</sub>  
 very little of anything<sub>(4)</sub>  
 only tube feedings<sub>(0)</sub>

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

- |   |  |
|---|--|
| <input type="checkbox"/> no problems eating <sub>(0)</sub>  | <input type="checkbox"/> no appetite, just did not feel like eating <sub>(3)</sub> |
| <input type="checkbox"/> nausea <sub>(1)</sub>              | <input type="checkbox"/> vomiting <sub>(3)</sub>                                   |
| <input type="checkbox"/> mouth sores <sub>(2)</sub>         | <input type="checkbox"/> things taste funny or have no taste <sub>(1)</sub>        |
| <input type="checkbox"/> problems swallowing <sub>(2)</sub> | <input type="checkbox"/> dry mouth <sub>(1)</sub>                                  |
| <input type="checkbox"/> feel full quickly <sub>(1)</sub>   | <input type="checkbox"/> smells bother me <sub>(1)</sub>                           |
| <input type="checkbox"/> constipation <sub>(1)</sub>        | <input type="checkbox"/> diarrhea <sub>(3)</sub>                                   |
| <input type="checkbox"/> pain: where? (3) _____             |  |
| <input type="checkbox"/> Other** (1) _____                  |  |

\*\* 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<sub>(0)</sub>  
 not my normal self, but able to be up and about with fairly normal activities<sub>(1)</sub>  
 not feeling up to most things, but in bed or chair less than half the day<sub>(2)</sub>  
 able to do little activity and spend most of the day in bed or chair<sub>(3)</sub>  
 pretty much bedridden, rarely out of bed<sub>(3)</sub>

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

**Total Score**



## PSSCAN-R 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 “Yes” or “No” by making a circle around the appropriate answer. There are no right or wrong answers.

- |   |     |    |
|---|-----|----|
| 1. Do you live alone?   | YES | NO |
| 2. When you need help, can you count on anyone to help with daily tasks such as 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 |

Part B: Please check all of the following items that have been of concern or a problem for you *in the past week including today.*\*

<p><b>6. Emotional:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fears/Worries</li> <li><input type="checkbox"/> Sadness</li> <li><input type="checkbox"/> Frustration/Anger</li> <li><input type="checkbox"/> Changes in appearance</li> <li><input type="checkbox"/> Intimacy/Sexuality</li> </ul>	<p><b>7. Informational:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Understanding my illness/treatment</li> <li><input type="checkbox"/> Talking with the health care team</li> <li><input type="checkbox"/> Making treatment decisions</li> <li><input type="checkbox"/> Knowing about available resources</li> </ul>
<p><b>8. Practical:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Work/School</li> <li><input type="checkbox"/> Finances</li> <li><input type="checkbox"/> Getting to &amp; from appointments</li> <li><input type="checkbox"/> Accommodation</li> </ul>	<p><b>9. Spiritual:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Meaning/Purpose of life</li> <li><input type="checkbox"/> Faith</li> </ul>
<p><b>10. Social/Family:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Feeling a burden to others</li> <li><input type="checkbox"/> Worry about family/friends</li> <li><input type="checkbox"/> Feeling alone</li> </ul>	<p><b>11. Physical:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Concentration/Memory</li> <li><input type="checkbox"/> Sleep</li> <li><input type="checkbox"/> Weight</li> </ul>

Other concerns, please specify: \_\_\_\_\_

\*Canadian Problem Checklist developed by the Canadian Partnership Against Cancer, August 2010.

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

	Not at all	A little bit	Moderately	Quite a bit	Very much
12. <b>During the past week</b> I have felt my heart race and I tremble.					
13. <b>During the past week</b> I have felt that I cannot control anything.					
14. <b>During the past week</b> I have lost interest in things I usually cared for or enjoyed.					
15. <b>During the past week</b> I have felt nervous and shaky inside.					
16. <b>During the past week</b> I have felt tense and cannot relax.					
17. <b>During the past week</b> my thoughts are repetitive and full of scary things.					
18. <b>During the past week</b> I have felt restless and find it difficult to sit still.					
19. <b>I have <i>recently</i></b> thought about taking my life. <b>NOTE: If you have, please speak with a member of your health care team and/or your family doctor.</b>					
20. <b>In the past year</b> , I have had 2 weeks or more during which I felt sad, blue or depressed.					
21. <b>I have had 2 years or more in my life</b> when I felt depressed or sad most days even if I felt okay 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 on our website. [www.bccancer.bc.ca/PPI/copingwithcancer](http://www.bccancer.bc.ca/PPI/copingwithcancer), or by calling:

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Telephone \_\_\_\_\_

<u>BCCA Patient &amp; Family Counselling Departments</u>	
Abbotsford Centre:	(604) 851-4733
Centre for Southern Interior:	(250) 712-3963
Centre for the North:	Opening 2012
Fraser Valley Centre:	(604) 930-4000
Vancouver Centre:	(604) 877-6000, L.67 2194
Vancouver Island Centre:	(250) 519-5525

<b>Patient &amp; Family Counselling Documentation:</b>
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