Cancer Care
Self-Assessment Questionnaire

Frederick Health

PATIENT NAME _____ DATE OF BIRTH _____ APPOINTMENT DATE _____

APPOINTMENT WITH

☐ Breast Surgery ☐ Chest Surgery ☐ Infusion Therapy ☐ Oncology & Hematology ☐ Radiation Medicine

☐ Other: _____

The following questionnaire may help determine whether you might benefit from professional counseling. Every patient experiences some of these symptoms; there are no right or wrong answers.

Remember when you answer these questions answer them honestly. If you try to create an impression that is different from how you truly feel, then you will not receive help that could make all the difference in your cancer experience. There are no right and wrong answers to the questions—they are purely meant to measure your feelings. The cancer care team wants to help you, the patient; they also want to make sure your family is coping.

Since diagnosis and/or the beginning of treatment:

1. I have felt anxious or worried about cancer and the treatment I am receiving

☐ **Not at all** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **All the time**

2. I have felt depressed or discouraged.

☐ **Not at all** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **All the time**

3. I have been irritable or unusually angry and I have not controlled it well.

☐ **Not at all** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **All the time**

4. I have difficulty coping with the stress I am experiencing or have experienced.

☐ **Not at all** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **All the time**

5. My family/those that love me have difficulty coping with the stress experienced as a result of my cancer diagnosis.

☐ **Not at all** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **All the time**

6. I have the necessary support from family, friends, and/or caregivers to successfully complete my treatment.

☐ **Almost never** ☐ **Sometimes** ☐ **Always**

7. My cancer diagnosis and its treatment have interfered with my daily activities.

☐ **Not at all** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **All the time**

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8. My cancer diagnosis and its treatment have interfered with my family or social life

☐ **Not at all** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **All the time**

9. I have had difficulty concentrating at work or at home, or on routine things such as reading the newspaper or watching television.

☐ **Not at all** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **All the time**

10. I am concerned cancer and its treatment have caused/will cause changes in my physical appearance

☐ **Not at all** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **All the time**

11. My sleeping habits have changed

☐ **Not at all** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **All the time** ☐ **I have reported this to my doctor/nurse.**

12. I have experienced a change in my appetite

☐ **Not at all** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **All the time** ☐ **I have reported this to my doctor/nurse.**

13. Pain and discomfort have caused me to limit my activities

☐ **Not at all** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **All the time** ☐ **I have reported this to my doctor/nurse.**

14. My cancer diagnosis and its treatment have interfered with my sexual life.

☐ **Not at all** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **All the time** ☐ **I have reported this to my doctor/nurse.**

15. My quality of life during the past two weeks has been

☐ **Excellent** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **Very poor**

16. Cancer diagnosis has financial hardship for me.

☐ **Not at all** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **All the time**

17. Do you have an Advance Directive? ☐ **YES** ☐ **NO**
If yes, please provide a copy to your provider.

18. Do you have transportation to and from the facility? ☐ **YES** ☐ **NO**

19. Are there needs and/or concerns you would like to discuss with Support Services?

Developed by the Department of Psychosocial Recourses, Tom Baker Cancer Centre, Calgary, Alberta, Canada. Derived in part from the Functional Living Index: Cancer and from the EORTC Core Quality of Life Questionnaire. Adapted from: Distress Treatment Guidelines for Patients, Version II/July 2005.