Distress Management Questionaire

Patient Name: _____ DOB: _____

Date of Service: _____ MR#: _____

Circle number that best describes how much distress you have been experiencing in the past week including today.

0 1 2 3 4 5 6 7 8 9 10

None Extreme

Please indicate if any of the following has been a problem for you in the past week including today.
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
☐	☐	Tingling in hands/feet

Comments: _____

Assessment Completed by: _____ Date/time: _____

Plan of Action

☐ Continued encouragement of reliance on social support system
☐ Medication Prescribed
☐ Referral to Primary Care Physician
☐ Referral to Patient Navigator
☐ Referral to Psychosocial Provider
☐ Other:
☐ Patient declined referral to Patient Navigator
☐ Patient declined referral to Psychosocial Provider

Comments: _____

_____

Physician : _____ Date/time: _____