

Concerns Checklist – identifying your concerns

Patient's name or label

Key worker: _____

Date: _____

Contact number: _____

This self assessment is optional. It has been designed to help us support you by identifying any concerns you may have and information you may require.

What do I need to do?

Select any areas that may have caused you concern recently and you would like to discuss with your key worker.

When selecting please score each concern between 1-10, with 1 being low level of concern and 10 the highest.

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

I have questions about my diagnosis, treatments or effects

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 plans
- 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 carer's support group
- Managing my symptoms
- Sun protection

Key worker to complete

Copy given to patient

Copy to be sent to GP

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MACMILLAN.
CANCER SUPPORT**