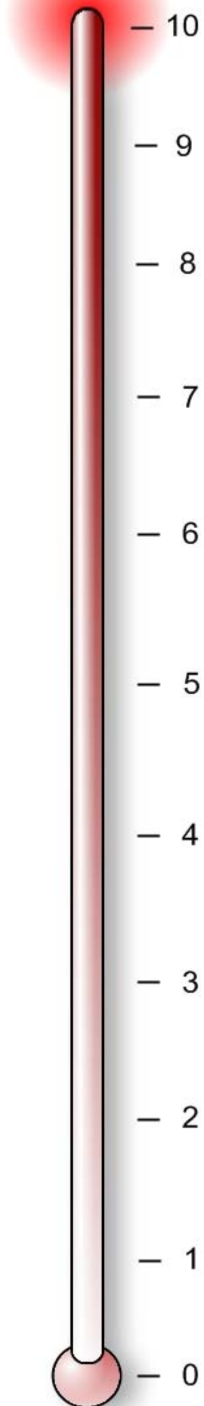
Well-being Assessment

Pan Birmingham NHS
Cancer Network

Using the thermometer, please circle a number that best describes how much distress you have felt in the past week, including today.

Next, please tick any of the following concerns that has been a cause of distress for you in the past week, including today.



Practical / Social Concerns:

- ❑ Child care
- ❑ Feeling lonely
- ❑ Getting to places
- ❑ Housework / Shopping
- ❑ Housing
- ❑ Money worries / Insurance
- ❑ Preparing meals / Drinks
- ❑ Washing / Dressing
- ❑ Walking / Getting around
- ❑ Work / College / School issues

Family / Relationship Concerns:

- ❑ Children
- ❑ Cultural needs
- ❑ Intimacy
- ❑ Looking after parents
- ❑ Partner
- ❑ People close to you
- ❑ Sexual functioning

Emotional Concerns:

- ❑ Anger
- ❑ Conflicting / Confusing information
- ❑ Confusion / Understanding
- ❑ Depression
- ❑ Fears / Worries
- ❑ Loss of interest in usual activities
- ❑ Nervousness
- ❑ Panicky
- ❑ Restlessness / Unable to relax
- ❑ Sadness / Grief
- ❑ Too much / Little information
- ❑ Unable to make plans

Physical Concerns:

- ❑ Balance / Dizziness
- ❑ Breathing difficulties / Coughing
- ❑ Body image
- ❑ Changes in bowel habit / Constipation or diarrhoea
- ❑ Changes in urination / Passing water
- ❑ Changes to skin/nails / hair
- ❑ Dry nose / Congested
- ❑ Eating / Drinking (swallowing)
- ❑ Fatigue / Tiredness
- ❑ Fertility
- ❑ Fevers / Temperature changes
- ❑ Genital / Gynaecological
- ❑ Hair thinning / Hair loss
- ❑ Hearing
- ❑ Indigestion
- ❑ Memory / Concentration
- ❑ Nausea / Vomiting
- ❑ Oral health / Sore mouth
- ❑ Pain / Changes in sensation
- ❑ Poor sleep
- ❑ Seeing
- ❑ Speech
- ❑ Swelling
- ❑ Tingling in Hands / Feet
- ❑ Weakness
- ❑ Weight
- ❑ Wound care

Spiritual / Religious Concerns:

- ❑ Changes in faith or beliefs
- ❑ Uncertainties around purpose / Meaning of life
- ❑ Why me

Other problems:

Would you like to talk about any of these issues? Yes / No

Well-being Assessment

Please write down your four main concerns below. The professionals supporting you will ask to see this checklist. They will find out more about your difficulties and help you plan how to address your concerns.

Main concerns:	Description	Plan of action
1		
2		
3		
4		

Patient Consent to share this assessment with:

GP	Yes	❑	No	❑
Copy in medical records	Yes	❑	No	❑
All relevant health care professionals	Yes	❑	No	❑
Specific health care professionals	Yes	❑	No	❑

Please state who: ______________________

Name of Patient:

NHS Number:

Date of today's assessment:

Previous assessment: yes / no

Staff name, job title and contact details: