Holistic Needs Assessment

Date

Name

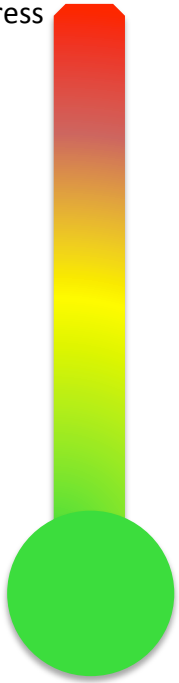
ID number

For each item below, please tick yes if they have been a concern for you during the last week, including today.

Choose not to complete the assessment today by ticking this box ☐

Please tick the number that best describes the overall level of distress you have been feeling during the last week, including today:

10 ☐ Extreme distress
9 ☐
8 ☐
7 ☐
6 ☐
5 ☐
4 ☐
3 ☐
2 ☐
1 ☐
0 ☐ No distress



Practical concerns

- ☐ Caring responsibilities
- ☐ Housing or finances
- ☐ Transport or parking
- ☐ Work or education Information needs
- ☐ Difficulty making plans
- ☐ Grocery shopping
- ☐ Preparing food Bathing or dressing
- ☐ Laundry or housework

Family concerns

- ☐ Relationship with children
- ☐ Relationship with partner
- ☐ Relationship with others

Emotional concerns

- ☐ Loneliness or isolation
- ☐ Sadness or depression
- ☐ Worry, fear or anxiety
- ☐ Anger, frustration or guilt
- ☐ Memory or concentration
- ☐ Hopelessness
- ☐ Sexual concerns

Spiritual concerns

- ☐ Regret about the past
- ☐ Loss of faith or other spiritual concern
- ☐ Loss of meaning or purpose in life

Physical concerns

- ☐ High temperature
- ☐ Wound care
- ☐ Passing urine
- ☐ Constipation or diarrhoea
- ☐ Indigestion
- ☐ Nausea and/or vomiting
- ☐ Cough
- ☐ Changes in weight
- ☐ Eating or appetite
- ☐ Changes in taste
- ☐ Sore or dry mouth
- ☐ Feeling swollen
- ☐ Breathlessness
- ☐ Pain
- ☐ Dry, itchy or sore skin
- ☐ Tingling in hands or feet
- ☐ Hot flushes
- ☐ Moving around or walking
- ☐ Fatigue
- ☐ Sleep problems
- ☐ Communication
- ☐ Personal appearance
- ☐ Other medical condition

My top 3 concerns are: 1) 2)
3)