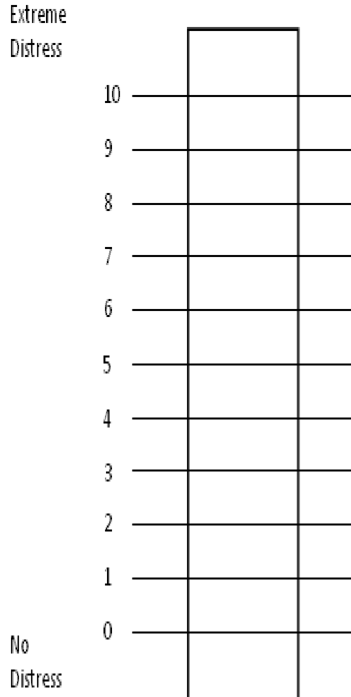
PALLIATIVE CARE REHABILITATION SERVICE
DISTRESS THERMOMETER

Patients Name:_____________________________ Date of Visit: ____________________________

During the past week how distressed have you been?



Check the causes of your distress

√ Please check all that apply

YES	NO	Practical Problems	YES	NO	Physical Problems
		Housing			Pain
		Insurance / Financial			Nauseau / vomiting
		Work / School			Fatigue
		Transportation			Sleep / insomnia
		Child / Parent			Getting around
FAMILY PROBLEMS					Bathing / dressing
		Partner			Breathing
		Children			Mouth Sores / swallowing
		Other (specify)			Loss of appetite
EMOTIONAL PROBLEMS					Talking
		Depression			Constipation / Diarrhea
		Nervousness / Anxiety			Changes in urination
					Tingling in hands / feet
					Sexual problems
					Skin dry / itch
					Swollen arms / legs
Spiritual/Religious Concerns			**Cognitive Problems**		
		Relating to God			Forgetfulness
		Loss of faith			Seeing/hearing things
		Facing my morality			Feeling confused
		Loss of my sense of purpose			Poor thinking
Information Concerns					
		Lack of information about my diagnosis			
		Lack of information about my treatment			
		Lack of information about alternative therapy choices			
		Lack of information about maintain fitness			
YES	**NO**	Do you wish to get help for an of the problems listed above?			
		If YES, which is/are most distressing?			
		If we cannot follow-up with you in clinic today, what is the best way to contact you?			