Distress Screening Form

PLACE PATIENT LABEL HERE

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 CONCERNS
☐	☐	Housing
☐	☐	Insurance/Financial
☐	☐	Work/School
☐	☐	Transportation
☐	☐	Treatment Decisions
☐	☐	Child/Adult Care
☐	☐	Information/Resources

YES	NO	PHYSICAL CONCERNS
☐	☐	Appearance
☐	☐	Concentration/Memory
☐	☐	Nutritional Concerns: I would like an appointment with the Registered Dietician, please contact me.
☐	☐	Substance Abuse
☐	☐	Sexual Concerns

YES	NO	
☐	☐	SPIRITUAL/RELIGIOUS CONCERNS

YES	NO	EMOTIONAL CONCERNS
☐	☐	Worry/Fears
☐	☐	Nervous/Anxiety
☐	☐	Sadness
☐	☐	Anger
☐	☐	Grief and/or loss

Depression:
Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

YES	NO	COMMUNICATION CONCERNS
☐	☐	Communicating with family
☐	☐	Communicating with staff

YES	NO	FAMILY CONCERNS
☐	☐	Dealing with partner or children
☐	☐	Abuse (physical, verbal, emotional, sexual)

Please circle the number (0-10) that best describes how much distress you have been experiencing in the **past week** including **today.**