Great Lakes Cancer Care Collaborative

A Questionnaire for Patients Completing Treatment

Please take a few minutes to provide us with information about how your cancer and your treatments have affected you, and turn it in to your nurse or therapist before you leave today. We'll use your responses to help us plan the next phase of your care, survivorship.

Patient Name: _____ DOB: _____

Diagnosis: _____ Date Completed Treatment: _____

Chemotherapy Regimen: _____

Radiation Description: _____

_____

As a cancer survivor you may experience some lasting side effects from your treatment. Please rate each topic according to how much distress it caused during your treatment. **The scale runs from 0 (no distress) to 5 (extreme distress).**

Physical Effects

	No Distress				Extreme Distress	
Fatigue	0	1	2	3	4	5
Pain	0	1	2	3	4	5
Sleep Disturbance	0	1	2	3	4	5
Sexual Issues / Intimacy	0	1	2	3	4	5
Body Changes	0	1	2	3	4	5
Balance / Walking / Mobility	0	1	2	3	4	5
Bowel or Bladder Changes	0	1	2	3	4	5
Weight Changes	0	1	2	3	4	5
Nausea / Vomiting	0	1	2	3	4	5
Poor Appetite	0	1	2	3	4	5
Swelling in Legs or Arms (Lymphedema)	0	1	2	3	4	5

	No Distress				Extreme Distress	
Hot Flashes / Menopause	0	1	2	3	4	5
Trouble Swallowing	0	1	2	3	4	5
Hair and Skin Care Issues	0	1	2	3	4	5
Dental or Mouth Problems	0	1	2	3	4	5
Osteoporosis / Bone Health	0	1	2	3	4	5
Memory and Concentration	0	1	2	3	4	5
Physical Therapy / Rehab	0	1	2	3	4	5
Tingling & Numbness in Feet & Hands (Neuropathy)	0	1	2	3	4	5
Other (Specify) _____	0	1	2	3	4	5
Other (Specify) _____	0	1	2	3	4	5

Social Issues

	No Distress				Extreme Distress	
Managing Household Activities	0	1	2	3	4	5
Caring for Family Members	0	1	2	3	4	5
Fertility Issues	0	1	2	3	4	5
Genetic Counseling (Worry About Your Children Getting Cancer)	0	1	2	3	4	5
Talking About Cancer with Family & Friends	0	1	2	3	4	5

	No Distress				Extreme Distress	
Returning to Work	0	1	2	3	4	5
Health Insurance	0	1	2	3	4	5
Legal Concerns	0	1	2	3	4	5
Financial Concerns	0	1	2	3	4	5
Debt from Medical Bills	0	1	2	3	4	5
Other (Specify) _____	0	1	2	3	4	5
Other (Specify) _____	0	1	2	3	4	5

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Emotional Aspects

	No Distress					Extreme Distress
Defining a New Sense of Normal	0	1	2	3	4	5
Managing Difficult Emotions (Anger, Fear, Sadness, Depression, Guilt, Anxiety, Uncertainty)	0	1	2	3	4	5
Coping with Grief and Loss	0	1	2	3	4	5
Finding Support Resources	0	1	2	3	4	5
Living with Uncertainty	0	1	2	3	4	5
Fear of Recurrence	0	1	2	3	4	5
Managing Stress	0	1	2	3	4	5
Looking for the Bright Side (Hope, Gratitude, Forgiveness, Love, Happiness, Contentment)	0	1	2	3	4	5
Connecting to Counseling Services	0	1	2	3	4	5
Changing Relationships with Spouse, Family, Friends, Co-Workers	0	1	2	3	4	5
Other (Specify) _____	0	1	2	3	4	5
Other (Specify) _____	0	1	2	3	4	5

Spiritual Issues

	No Distress					Extreme Distress
Religious or Spiritual Support	0	1	2	3	4	5
Loss of Faith	0	1	2	3	4	5
Religious Distress	0	1	2	3	4	5
End of Life Distress	0	1	2	3	4	5
Isolation / Feeling Alone	0	1	2	3	4	5
Other (Specify) _____	0	1	2	3	4	5

Other Issues

	No Distress					Extreme Distress
Staying Connected with the Medical System	0	1	2	3	4	5
Who to Call for Medical Problems	0	1	2	3	4	5
Keeping Your Primary Care Physician Informed of Your Cancer Treatment & Risk of Recurrence	0	1	2	3	4	5
Use of Complementary and Alternative Therapies	0	1	2	3	4	5
Concern About Long-Term Effects of Treatment	0	1	2	3	4	5
Having a Sense of Well Being	0	1	2	3	4	5
Other (Specify) _____	0	1	2	3	4	5
Other (Specify) _____	0	1	2	3	4	5

What Specific Topics are You Interested in Learning About?

HEALTHY LIVING CHOICES ❑ Nutrition ❑ Safe Exercise ❑ Smoking Cessation

FINANCIAL CONCERNS ❑ Estate Planning ❑ Living Wills ❑ Disability

ENHANCING COMMUNICATION ❑ With Your Doctors ❑ With Your Spouse

HEALTH SCREENINGS ❑ Cancer ❑ Heart

COMMUNITY EDUCATION PROGRAMS ON VARIOUS TOPICS ❑ Yes ❑ No

As you end your treatments, what questions, concerns, or thoughts do you have regarding your healthcare needs?

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_____

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Additional Comments _____

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Adapted for use from a Survey of Needs from the Mayo Clinic Cancer Center.