

Patient name: _____
 Address: _____
 Date of birth: _____
 Phone #: _____
 PHN: _____

PATIENT LABEL

Please circle the number that best describes how you feel <u>now</u> :		
No pain	0 1 2 3 4 5 6 7 8 9 10	Worst possible pain
No tiredness <i>(tiredness = lack of energy)</i>	0 1 2 3 4 5 6 7 8 9 10	Worst possible tiredness
No drowsiness <i>(drowsiness = feeling sleepy)</i>	0 1 2 3 4 5 6 7 8 9 10	Worst possible drowsiness
No nausea	0 1 2 3 4 5 6 7 8 9 10	Worst possible nausea
No lack of appetite	0 1 2 3 4 5 6 7 8 9 10	Worst possible lack of appetite
No shortness of breath	0 1 2 3 4 5 6 7 8 9 10	Worst possible shortness of breath
No depression <i>(depression = feeling sad)</i>	0 1 2 3 4 5 6 7 8 9 10	Worst possible depression
No anxiety <i>(anxiety = feeling nervous)</i>	0 1 2 3 4 5 6 7 8 9 10	Worst possible anxiety
Best wellbeing <i>(wellbeing = how you feel overall)</i>	0 1 2 3 4 5 6 7 8 9 10	Worst possible wellbeing
No _____ other problem <i>(for example constipation)</i>	0 1 2 3 4 5 6 7 8 9 10	Worst possible

Completed by: (check one)

- Patient
- Family caregiver
- Health care professional caregiver
- Caregiver-assisted

Date and time: _____

Please mark on these pictures where it is that you hurt:

