northern health
the northern way of caring

(FACILITY)

Hospice Palliative Care Program

EDMONTON SYMPTOM ASSESSMENT SYSTEM NUMERICAL SCALE

Patient's Name: _____

Address: _____

_____ Postal Code: _____

Date of Birth: _____

Phone Number: _____

PHN: _____

(or Addressograph or Stamp)

Please Circle the Number that Best Describes												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Pain
Not Tired	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Tiredness
Not Nauseated	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Nausea
Not Depressed	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Depression
Not Anxious	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Anxiety
Not Drowsy	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Drowsiness
Best Appetite	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Appetite
Best Feeling of Well Being	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Feeling of Well Being
No Shortness of Breath	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Shortness of Breath
Other Problems	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

Assessed By: ☐ Patient ☐ Caregiver ☐ Nurse _____

Signature

Date & Time: _____

Adapted from the Edmonton Symptom Assessment System (ESAS) With permission.