

Hornheide Screening Instrument

1. How did you feel physically in the last 3 days?	rather good 0	medium 1	rather poor 2
2. How did you feel mentally in the last 3 days?	rather good 0	medium 1	rather poor 2
3. Is there anything that weighs heavily on you regardless of the current illness?	yes 2	no 0	
4. Do you have someone to talk to about your fears and concerns?	yes 0	no 2	
5. Is anyone in your family particularly burdened by the hospital stay?	yes 2	no 0	
6. Can you find inner peace during the day?	yes 0	no 2	
7. How well do you feel informed about the disease and treatment?	rather good 1	medium 2	rather poor 3

Distress Thermometer

SCREENING TOOLS FOR MEASURING DISTRESS

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

Extreme distress

No distress

Second, 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.

<p>YES NO <u>Practical Problems</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Child care</p> <p><input type="checkbox"/> <input type="checkbox"/> Housing</p> <p><input type="checkbox"/> <input type="checkbox"/> Insurance/financial</p> <p><input type="checkbox"/> <input type="checkbox"/> Transportation</p> <p><input type="checkbox"/> <input type="checkbox"/> Work/school</p> <p>Family Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Dealing with children</p> <p><input type="checkbox"/> <input type="checkbox"/> Dealing with partner</p> <p>Emotional Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Fears</p> <p><input type="checkbox"/> <input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> <input type="checkbox"/> Sadness</p> <p><input type="checkbox"/> <input type="checkbox"/> Worry</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of interest in usual activities</p> <p><input type="checkbox"/> <input type="checkbox"/> <u>Spiritual/religious concerns</u></p>	<p>YES NO <u>Physical Problems</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Appearance</p> <p><input type="checkbox"/> <input type="checkbox"/> Bathing/dressing</p> <p><input type="checkbox"/> <input type="checkbox"/> Breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> Changes in urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> Eating</p> <p><input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> Feeling Swollen</p> <p><input type="checkbox"/> <input type="checkbox"/> Fevers</p> <p><input type="checkbox"/> <input type="checkbox"/> Getting around</p> <p><input type="checkbox"/> <input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> <input type="checkbox"/> Memory/concentration</p> <p><input type="checkbox"/> <input type="checkbox"/> Mouth sores</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> Nose dry/congested</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Skin dry/itchy</p> <p><input type="checkbox"/> <input type="checkbox"/> Sleep</p> <p><input type="checkbox"/> <input type="checkbox"/> Tingling in hands/feet</p>
---	--

Other Problems: _____
