Providence
Montana Cancer Center

Distress Screening Tool

Patient Name: _____
Patient Phone Number: _____
Patient DOB: _____

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

No Distress **Extreme Distress**

0	1	2	3	4	5	6	7	8	9	10

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

No Fatigue **Extreme Fatigue**

0	1	2	3	4	5	6	7	8	9	10

Would you like information about any of the following resources?

YES	NO		YES	NO	
☐	☐	Support groups	☐	☐	Exercise and movement
☐	☐	Counseling	☐	☐	Smoking cessation
☐	☐	Educational classes	☐	☐	Integrative medicine
☐	☐	Nutrition	☐	☐	Power of attorney/living wills
☐	☐	Fertility			Other _____
☐	☐	Clinical trials			

Please indicate any additional areas of concern that haven't been mentioned already.

YES	NO		YES	NO	
☐	☐	Eating concerns	☐	☐	Getting around
☐	☐	Breathing	☐	☐	Memory/concentration
☐	☐	Appearance	☐	☐	Pain
☐	☐	Weight loss			Other _____
☐	☐	Sleep			

Please indicate if any of the following have been a problem for you in the past week including today. Be sure to check YES or NO for each.

Practical Problems:

YES	NO	
☐	☐	Financial concerns
☐	☐	Transportation
☐	☐	Treatment decisions
☐	☐	Disability
☐	☐	Housing
☐	☐	Work/school
☐	☐	Caregiving
		Other _____

Emotional Problems:

YES	NO	
☐	☐	Sadness
☐	☐	Anger
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Fear
☐	☐	Fear of dying
☐	☐	Questioning values, faith or God
		Other _____

Would you like support for any of the following concerns?

YES	NO	
☐	☐	Talking with spouse/partner
☐	☐	Support for spouse/partner
☐	☐	Talking with my children
☐	☐	Sexual intimacy
		Other _____

Reviewed by: _____ Date: _____