Symptom Assessment Form

Documentation Date	☐☐☐☐ /☐☐/☐☐ (yyyy/mm/dd)	*Note: this form can be completed by the patient at any time.*

Please circle the number that BEST describes how you feel NOW:

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst possible pain
No tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst possible tiredness
No drowsiness *(Drowsiness = feeling sleepy)*	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 *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst possible depression
No anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst possible anxiety
Best well-being *(Well-being = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst possible well-being
No _____	0	1	2	3	4	5	6	7	8	9	10	Worst possible _____

Outcome