PSYCHOSOCIAL INFORMATION NAME: _____

1. With whom do you live? Name _____Relationship _____
   Nearest friend or relative we may call in an emergency? Name _____
   Address _____ Phone _____
2. Do you drive? **YES / NO** If not, who drives you? _____
3. Is there someone who can help you, if needed? _____
4. Your occupation _____Current employment status: Employed/Unemployed/Retired/Disabled
5. Do you have concerns about your insurance or your ability to pay for your care? **YES / NO**
6. Are you receiving home care currently? **YES / NO** If Yes, with whom? _____
7. Does your medical condition interfere with your ability to do:

	ALWAYS	SOMETIMES	NEVER
Personal Care			
Shopping, errands			
Housekeeping, laundry			
Bills			
Cooking			

8. Circle any of the following which apply to how you are feeling about being here today:

ANGRY ANXIOUS CONCERNED HELPLESS HOPELESS DEPRESSED SCARED
POSITIVE SUPPORTED ISOLATED OVERWHELMED HOPEFUL RELIEVED
OTHER_____

9. Please rate your level of anxiety about your diagnosis on the scale below:

MILD					MODERATE				HIGH
1	2	3	4	5	6	7	8	9	10

10. Are you able to talk to your family or friends about your illness? **YES / NO**
11. Are you interested in support groups or educational programs? **YES / NO**
12. Do you have religious/cultural/spiritual beliefs that we should be aware of to better care for you? _____
13. Are there any barriers to your care that we should be aware of? _____
14. Are you interested in learning more about complementary services such as meditation, relaxation techniques, guided visualization, yoga or Reiki therapy? _____

NUTRITIONAL INFORMATION

1. Have you had any recent unintentional weight loss?
   YES / NO
2. If yes, amount of weight loss
   _____
3. Over what period of time?
   _____
4. Are you using any vitamin, mineral, herbal or other supplements?
   YES / NO
   If Yes, please list:
   _____
   _____
   _____
   _____
5. Are you having any problems eating?
   YES / NO
6. Please check any of the following that you are experiencing:
   - ☐ Loss of appetite
   - ☐ Vomiting
   - ☐ Chewing difficulties
   - ☐ Swallowing difficulties
   - ☐ Taste changes
   - ☐ Diarrhea
   - ☐ Nausea
   - ☐ Mouth sores
   - ☐ Dry mouth
   - ☐ Constipation
   - ☐ Other _____
7. Are you interested in more information about cancer risk assessment? **YES / NO**
8. Are you interested in more information about clinical trials/research? **YES / NO**
9. Do you have an Advance Directive?
   YES / NO
10. Does HMC have a copy? **YES / NO**
11. Would you like information about the Advance Directive? **YES / NO / NA**

TO BE COMPLETED BY STAFF

Copy in chart? **YES / NO**
Copy sent to HMC Medical Records Dept?
YES / NO Date sent: _____
Reviewed by: _____
Date: _____
Presented to New Patient Team:
Date: _____ By: _____

REFERRALS:
To Social Worker **YES / NO**
Reason _____
Date: _____
To Clinical Dietitian **YES / NO**
Date: _____
To Other: _____
Date: _____