

DISTRESS THERMOMETER

Patient Label

☐ Initial Consult ☐ Pre-Treatment ☐ Follow-up/Change in care

Printed Name: _____

Date of Birth: ____/____/____

Preferred Phone Number: _____

May We Leave a Message? ☐ Yes ☐ No

Patient Signature: _____

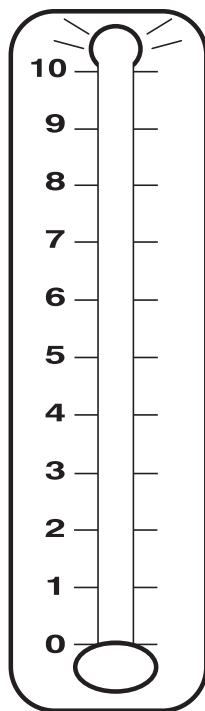
Today's Date: _____

NCCN Distress Thermometer

Distress is an unpleasant experience of a mental, physical, social, or spiritual nature. It can affect the way you think, feel or act. Distress may make it harder to cope with having cancer, its symptoms, or its treatment.

Instructions: 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

PROBLEM LIST

Have you had concerns about any of the items below in the past week, including today? (Mark all that apply)

Physical Concerns

- ☐ Pain
- ☐ Sleep
- ☐ Fatigue
- ☐ Tobacco use
- ☐ Substance use
- ☐ Memory or concentration
- ☐ Sexual health
- ☐ Changes in eating
- ☐ Loss or change of physical abilities

Emotional Concerns

- ☐ Worry or anxiety
- ☐ Sadness or depression
- ☐ Loss of interest or enjoyment
- ☐ Grief or loss
- ☐ Fear
- ☐ Loneliness
- ☐ Anger
- ☐ Changes in appearance
- ☐ Feeling of worthlessness or being a burden

Social Concerns

- ☐ Relationship with spouse or partner
- ☐ Relationship with children
- ☐ Relationship with family members
- ☐ Relationship with friends or coworkers
- ☐ Communication with health care team
- ☐ Ability to have children
- ☐ Prejudice or discrimination

Practical Concerns

- ☐ Taking care of myself
- ☐ Taking care of others
- ☐ Safety
- ☐ Work
- ☐ School
- ☐ Housing/Utilities
- ☐ Finances
- ☐ Insurance
- ☐ Transportation
- ☐ Childcare
- ☐ Having enough food
- ☐ Access to medicine
- ☐ Treatment decisions

Spiritual or Religious Concerns

- ☐ Sense of meaning or purpose
- ☐ Changes in faith or beliefs
- ☐ Death, dying, or afterlife.
- ☐ Conflict between beliefs and cancer treatments
- ☐ Relationship with the sacred
- ☐ Ritual or dietary needs

Other Concerns

To Be Completed by Medical Staff

Primary Diagnosis: _____

☐ + Cancer Dx

Provider Signature: _____

Provider Name (printed): _____

Date: _____

Modified form for local population 01/2025, based on NCCN Guidelines Version 1.2025 Distress Management, 11/18/2024 © 2024 National Comprehensive Cancer Network®



6628 Cancer Care

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(01/2024)