

For staff use

Patient number:

Input boxes for patient number

# IPOS Patient Version



www.pos-pal.org

Name: .....

Date (dd/mm/yyyy):

Date input boxes

Please write clearly, one letter or digit per box. Your answers will help us to keep improving your care and the care of others.

Thank you.

### Q1. What have been your main problems or concerns over the past week?

Three lines for listing main problems or concerns

### Q2. Below is a list of symptoms, which you may or may not have experienced. For each symptom, please tick one box that best describes how it has affected you over the past week.

	<i>Not at all</i>	<i>Slightly</i>	<i>Moderately</i>	<i>Severely</i>	<i>Overwhelmingly</i>
Pain	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Shortness of breath	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Weakness or lack of energy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Nausea (feeling like you are going to be sick)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Vomiting (being sick)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Poor appetite	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Constipation	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Sore or dry mouth	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Drowsiness	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Poor mobility	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

Please list any other symptoms not mentioned above, and tick one box to show how they have affected you over the past week.

1. _____	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2. _____	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3. _____	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

**Over the past week:**

	<i>Not at all</i>	<i>Occasionally</i>	<i>Sometimes</i>	<i>Most of the time</i>	<i>Always</i>
<b>Q3. Have you been feeling anxious or worried about your illness or treatment?</b>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>Q4. Have any of your family or friends been anxious or worried about you?</b>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>Q5. Have you been feeling depressed?</b>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

	<i>Always</i>	<i>Most of the time</i>	<i>Sometimes</i>	<i>Occasionally</i>	<i>Not at all</i>
<b>Q6. Have you felt at peace?</b>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>Q7. Have you been able to share how you are feeling with your family or friends as much as you wanted?</b>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>Q8. Have you had as much information as you wanted?</b>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

	<i>Problems addressed/ No problems</i>	<i>Problems mostly addressed</i>	<i>Problems partly addressed</i>	<i>Problems hardly addressed</i>	<i>Problems not addressed</i>
<b>Q9. Have any practical problems resulting from your illness been addressed? (such as financial or personal)</b>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

	<i>On my own</i>	<i>With help from a friend or relative</i>	<i>With help from a member of staff</i>
<b>Q10 How did you complete this questionnaire?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*If you are worried about any of the issues raised on this questionnaire then please speak to your doctor or nurse*