

For staff use
Patient number:

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IPOS Patient Version



www.pos-pal.org

Name:

Date (dd/mm/yyyy):

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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?

1. _____

2. _____

3. _____

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 1 2 3 4

2. _____ 0 1 2 3 4

3. _____ 0 1 2 3 4

Over the past week:

	<i>Not at all</i>	<i>Occasionally</i>	<i>Sometimes</i>	<i>Most of the time</i>	<i>Always</i>
Q3. Have you been feeling anxious or worried about your illness or treatment?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Q4. Have any of your family or friends been anxious or worried about you?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Q5. Have you been feeling depressed?	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>
Q6. Have you felt at peace?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Q7. Have you been able to share how you are feeling with your family or friends as much as you wanted?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Q8. Have you had as much information as you wanted?	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>
Q9. Have any practical problems resulting from your illness been addressed? (such as financial or personal)	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>
Q10 How did you complete this questionnaire?	<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