Aintree Holistic Needs Assessment

Getting it **right** for **every** patient **every** time

HaNC

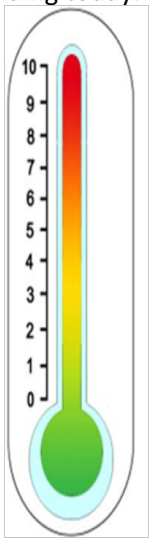
For each item below, please select **yes** or **no** if they have been a concern for you during the last week, including today. Please also select **discuss** if you wish to speak about it with your health professional.

Choose not to complete the assessment today by selecting this box ☐

Date:	
Name:	
Hospital/NHS number:	

Please **select the number** that best describes the overall level of distress you have been feeling during the last week, including today:

10 ☐ **Extreme distress**
9 ☐
8 ☐
7 ☐
6 ☐
5 ☐
4 ☐
3 ☐
2 ☐
1 ☐
0 ☐ **No distress**



For health professional use	
Date of diagnosis:	
Diagnosis:	
Pathway point:	

Physical and functional well being	**Yes**	**No**	**Discuss**
Activity	☐	☐	☐
Appetite	☐	☐	☐
Bowel habit	☐	☐	☐
Breathing	☐	☐	☐
Chewing/Eating	☐	☐	☐
Coughing	☐	☐	☐
Dental health/teeth	☐	☐	☐
Dry mouth	☐	☐	☐
Energy levels	☐	☐	☐
Fatigue/tiredness	☐	☐	☐
Hearing	☐	☐	☐
Indigestion	☐	☐	☐
Mobility	☐	☐	☐
Mouth opening	☐	☐	☐
Mucus	☐	☐	☐
Nausea	☐	☐	☐
Pain in the head and neck	☐	☐	☐
Pain elsewhere	☐	☐	☐
Regurgitation	☐	☐	☐
Salivation	☐	☐	☐
Shoulder	☐	☐	☐
Sleeping	☐	☐	☐
Smell	☐	☐	☐
Sore Mouth	☐	☐	☐
Swallowing	☐	☐	☐
Swelling	☐	☐	☐
Taste	☐	☐	☐
Vomiting/sickness	☐	☐	☐
Weight	☐	☐	☐

Treatment related	**Yes**	**No**	**Discuss**
Cancer treatment	☐	☐	☐
Regret about treatment	☐	☐	☐
PEG tube	☐	☐	☐
Wound healing	☐	☐	☐
Social care and social well-being			
Carer	☐	☐	☐
Dependants/Children	☐	☐	☐
Financial Benefits	☐	☐	☐
Home Care/District Nurse	☐	☐	☐
Lifestyle Issues (smoking/alcohol)	☐	☐	☐
Recreation	☐	☐	☐
Relationships	☐	☐	☐
Speech/Voice/Being understood	☐	☐	☐
Support for my family	☐	☐	☐
Psychological - Emotional - Spiritual			
Appearance	☐	☐	☐
Angry	☐	☐	☐
Anxiety	☐	☐	☐
Coping	☐	☐	☐
Depression	☐	☐	☐
Fear of cancer coming back	☐	☐	☐
Fear of adverse events	☐	☐	☐
Intimacy	☐	☐	☐
Memory	☐	☐	☐
Mood	☐	☐	☐
Self-esteem	☐	☐	☐
Sexuality	☐	☐	☐
Spiritual/Religious aspects	☐	☐	☐
Personality and temperament	☐	☐	☐

Care Plan

During my holistic needs assessment, these issues were identified and discussed:

Preferred name: **Hospital/NHS number:**

Num	Issue	Summary of discussion	Actions required/by (name and date)
1			
2			
3			
4			
5			

Other actions/outcomes e.g. additional information given, health promotion, smoking cessation, 'My actions':

Signed (patient):	Date:
Signed (healthcare professional):	Date:

For health professional use		
Date of diagnosis:	Diagnosis:	Pathway point: