

Patient Questionnaire

Assessing Your Experience

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Please answer the following questions **based on your life at this time.**

Circle the number from 0 – 10 that best describes your experiences.

Physical Area

To what extent are the following a problem for you:

1. Fatigue

No problem 0 1 2 3 4 5 6 7 8 9 10 *Severe problem*

2. Sleep changes

No problem 0 1 2 3 4 5 6 7 8 9 10 *Severe problem*

3. Problems with dry mouth, change in food tastes, drooling or appetite changes

No problem 0 1 2 3 4 5 6 7 8 9 10 Severe problem

4. Intestinal problems of constipation or diarrhea

No problem 0 1 2 3 4 5 6 7 8 9 10 Severe problem

5. Nausea

No problem 0 1 2 3 4 5 6 7 8 9 10 Severe problem

6. Shortness of breath or difficulty breathing

No problem 0 1 2 3 4 5 6 7 8 9 10 Severe problem

7. Aches or pain

No problem 0 1 2 3 4 5 6 7 8 9 10 Severe problem

8. Please rate your current pain

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine

Emotional / Relationship Area

9. How satisfying is your life?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Completely

10. How much anxiety do you have?

None at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

11. How free are you to express feeling of sadness, grief, and anger?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Completely

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12. Do you have enough opportunity to talk about your illness, experiences, and possible death?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Completely

13. How much do you feel like you are a burden for your family?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Completely

14. How much do you worry about family and friends not being there for you?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

15. Have family / friends given specific support without you asking?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

16. Is the amount of support you are receiving meeting your needs?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Completely

17. How much isolation from others do you feel is caused by your illness or treatment?

None at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

18. How much of your treatment wishes and goals do your family / friends know?

None at all 0 1 2 3 4 5 6 7 8 9 10 Completely

**19. If you are still working, has your work place been supportive?
(leave blank if not still working)**

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

Spiritual Area

20. How important to you is your participation in spiritual or religious experiences (e.g. meditation, spiritual traditions or rituals, praying, or going to a place of worship)?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Very important

21. To what extent has your illness made positive changes in your life?

None at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

22. Do you sense a purpose / mission for your life or a reason for being

alive?

None at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

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23. How hopeful do you feel?

Not at all hopeful 0 1 2 3 4 5 6 7 8 9 10 Very hopeful

24. How much opportunity have you had to reflect on your life?

None at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

25. Do you view time as precious and value each minute of life?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

26. Have you experienced healing in spiritual, emotional, relational areas

of your life?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

Please share other comments about your experience

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Place of Care Environment (Health Care Experience)

1. Experience receiving effective and timely pain management

No problem 0 1 2 3 4 5 6 7 8 9 10 Severe problem

2. Experience receiving effective and timely symptom relief, e.g. difficulty breathing, nausea, constipation.

No problem 0 1 2 3 4 5 6 7 8 9 10 Severe problem

3. Adequate help for meeting your physical needs at home

No problem 0 1 2 3 4 5 6 7 8 9 10 Severe problem

4. Were you given enough information about your care and treatment choices to prepare you for your experience with care and treatments?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Completely

5. How difficult was it to find out information about your illness, care, and treatment choices?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

6. If there was a conflict over your care, did you feel supported in having your care wishes honored?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

7. Did you feel that you had appropriate control over your care choices and health care experiences?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Completely

8. Did you feel free to refuse care or treatments?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Completely

9. Did your family feel welcomed 24 hours a day and with each appointment?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Completely

10. Was your privacy and confidentiality respected?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

11. Were you given information about support groups or put in touch with others who had similar experiences?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

12. Do you have enough access to and opportunity to talk with professional counselors?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

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13. Were you given the opportunity to have chaplains or others pray with and for you or to say no to their praying with or for you?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

14. Did the health care team ask about your Living Will or advance care planning?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

15. Please rate your overall experience with the quality of your health services

Very inconsistent 0 1 2 3 4 5 6 7 8 9 10 Consistently high

16. Have those caring for you had a good understanding of your illness, treatment, and care wishes?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

17. Have people consistently followed through on your care wishes?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

18. Did you get enough help obtaining and completing applications and financial forms, e.g. insurance, social security, disability?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

19. Did you get enough help finding needed resources and support, e.g.

transportation or homemaker assistance?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

**DOCTORS, NURSES, OTHER HEALTH CARE PROVIDERS /
COMMUNICATION**

20. Have you felt caring, respect, and genuine presence from your doctor?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

**21. Have you felt caring, respect, and genuine presence from your nurses
and others?**

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

**22. Was your doctor's communication with you easy to understand and
consistent?**

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

**23. Was your nurse's communication with you easy to understand and
consistent?**

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

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24. Did you feel supported by your doctors if you looked for second opinions and other care choices?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

25. To what extent has communication with healthcare personnel assisted you to maintain hope?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

26. How much do you worry about physicians and other professionals not being there for you?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

27. If you had questions about “complementary therapies”, did your doctors’ answer your questions to your satisfaction?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

28. Have your doctor(s) provided you the opportunity to discuss possible death?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

29. Have your nurses / others provided you the opportunity to discuss possible death?

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

Please share other comments about your experience

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Information About You

Please complete the following questions about you. This information will be kept strictly confidential.

Location Where Questionnaire Completed:

Home Hospital Long Term Care Dr's Office

Other (*please specify*) _____

Age _____ Gender: Male Female

Diagnosis or illness that seems to be life – threatening:

Race/Ethnicity Religion

White/Caucasian Jewish Muslim

Black/African American Catholic Buddhist

Asian or Pacific Islander Jehovah's Witness Bahia

Hispanic Christian Scientist No religion

Native American Seventh Day Adventist Other (*specify*):

Other Protestant

Native American _____

Insurance:

Private/Commercial insurance No insurance / self-payment

Medicare Other insurance

Medicaid

Health Maintenance Organization (HMO) yes no

Yearly household income before taxes:

less than \$25,000 \$75,001 - \$100,000

\$25,001 - \$50,000 more than \$100,000

\$50,001 - \$75,000

Current Living Arrangements:

Living alone at home Assisted Living

Home with family / friends Nursing Home

Living with family / friends in their home

Health Services you are receiving:

Home Health Church based ministries, e.g. Stephen Ministries

Hospice Visiting Nurse

Parish Nurse Other (specify): _____

Please call me about my care or this questionnaire yes no

Date Questionnaires completed _____ I.D. number _____