Graph 1

Figure 3. Leading Sites of New Cancer Cases and Deaths – 2017 Estimates

Estimated New Cases

Male				Female		
Prostate	161,360	19%		Breast	252,710	30%
Lung & bronchus	116,990	14%		Lung & bronchus	105,510	12%
Colon & rectum	71,420	9%		Colon & rectum	64,010	8%
Urinary bladder	60,490	7%		Uterine corpus	61,380	7%
Melanoma of the skin	52,170	6%		Thyroid	42,470	5%
Kidney & renal pelvis	40,610	5%		Melanoma of the skin	34,940	4%
Non-Hodgkin lymphoma	40,080	5%		Non-Hodgkin lymphoma	32,160	4%
Leukemia	36,290	4%		Leukemia	25,840	3%
Oral cavity & pharynx	35,720	4%		Pancreas	25,700	3%
Liver & intrahepatic bile duct	29,200	3%		Kidney & renal pelvis	23,380	3%
All sites	**836,150**	**100%**		**All sites**	**852,630**	**100%**

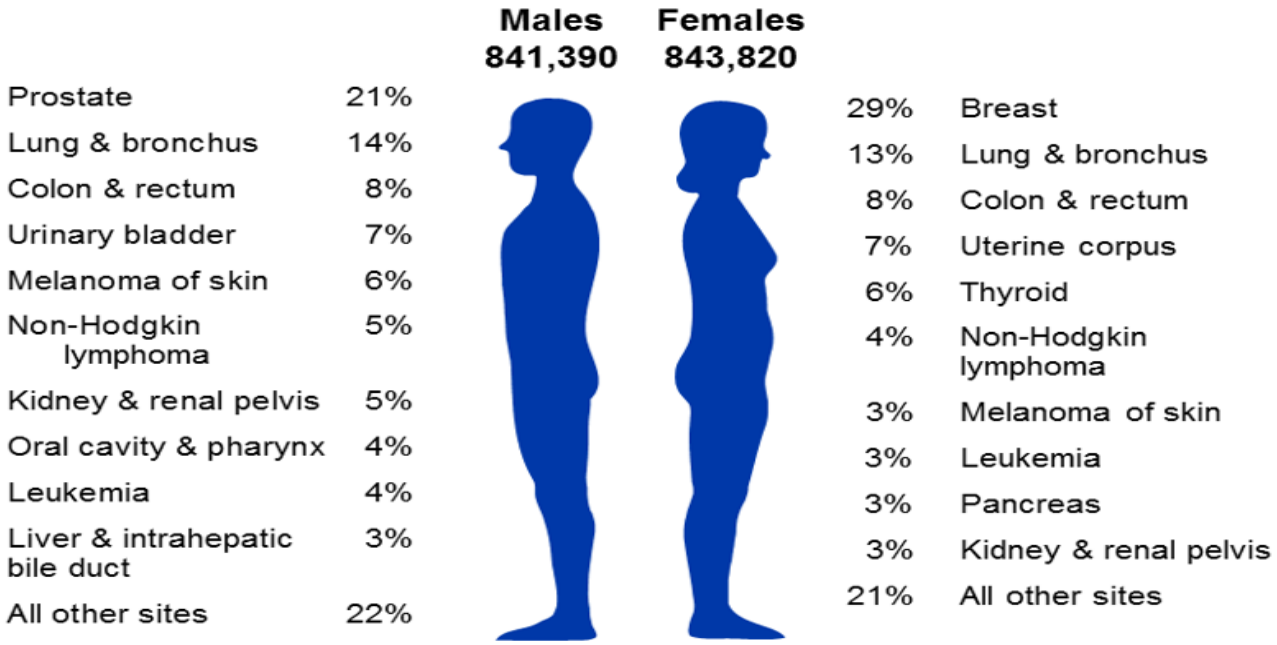
Estimated Deaths

Male				Female		
Lung & bronchus	84,590	27%		Lung & bronchus	71,280	25%
Colon & rectum	27,150	9%		Breast	40,610	14%
Prostate	26,730	8%		Colon & rectum	23,110	8%
Pancreas	22,300	7%		Pancreas	20,790	7%
Liver & intrahepatic bile duct	19,610	6%		Ovary	14,080	5%
Leukemia	14,300	4%		Uterine corpus	10,920	4%
Esophagus	12,720	4%		Leukemia	10,200	4%
Urinary bladder	12,240	4%		Liver & intrahepatic bile duct	9,310	3%
Non-Hodgkin lymphoma	11,450	4%		Non-Hodgkin lymphoma	8,690	3%
Brain & other nervous system	9,620	3%		Brain & other nervous system	7,080	3%
All sites	**318,420**	**100%**		**All sites**	**282,500**	**100%**

Estimates are rounded to the nearest 10, and cases exclude basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder.

Graph 2

Estimated New Cancer Cases* in the US in 2016



*Excludes basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder.

ACS www.cancer.org

Graph 3

The Lifetime Probability of Developing Cancer for Males, 2010-2012

Site	Risk
All sites*	1 in 2
Prostate	1 in 7
Lung & bronchus	1 in 14
Colon & rectum	1 in 21
Urinary bladder†	1 in 26
Melanoma of the skin‡	1 in 33
Non-Hodgkin lymphoma	1 in 42
Kidney & renal pelvis	1 in 49
Leukemia	1 in 57
Oral cavity & pharynx	1 in 64
Pancreas	1 in 65

*All sites exclude basal cell and squamous cell skin cancers and in situ cancers except urinary bladder. †Includes invasive and in situ cancer cases
‡Statistic for white males.
Source: DevCan: Probability of Developing or Dying of Cancer Software, Version 6.7.3 Statistical Research and Applications Branch, National Cancer Institute, 2015.

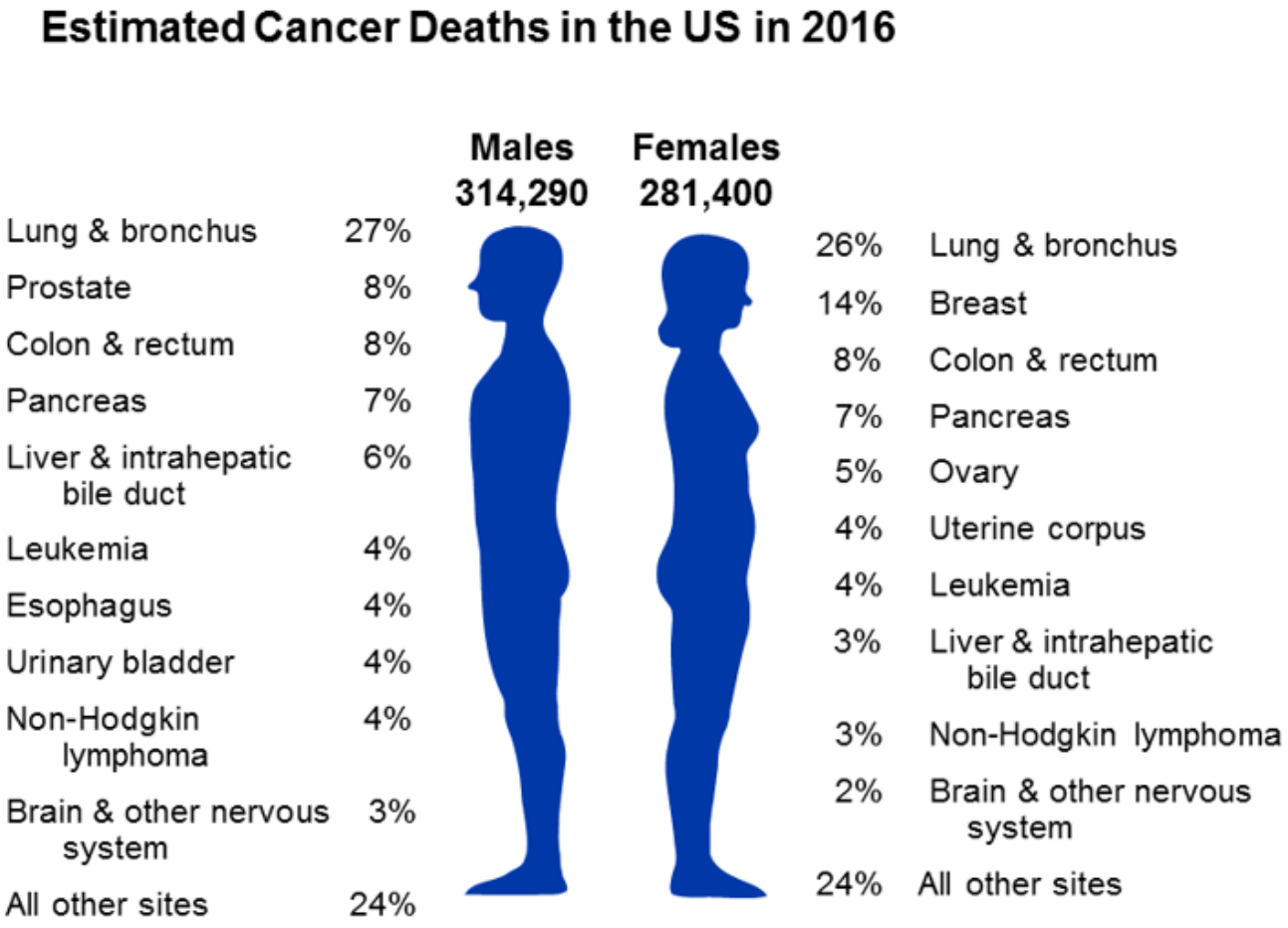
Graph 4

The Lifetime Probability of Developing Cancer for Females, 2010-2012

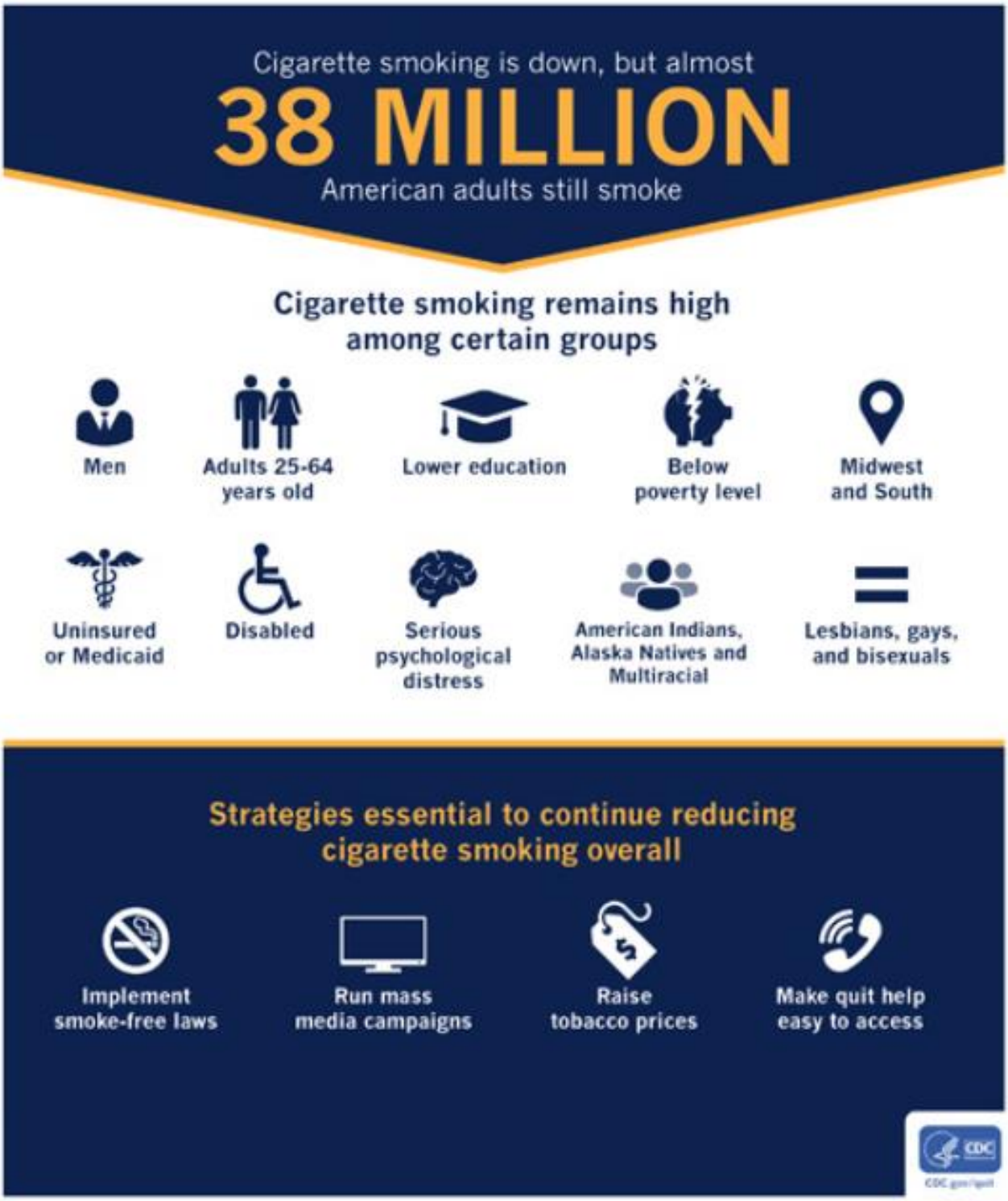
Site	Risk
All sites*	1 in 3
Breast	1 in 8
Lung & bronchus	1 in 17
Colon & rectum	1 in 23
Uterine corpus	1 in 36
Melanoma of the skin†	1 in 52
Non-Hodgkin lymphoma	1 in 53
Thyroid	1 in 58
Pancreas	1 in 67
Ovary	1 in 77
Leukemia	1 in 82

*All sites exclude basal cell and squamous cell skin cancers and in situ cancers except urinary bladder. †Statistic for white females.
Source: DevCan: Probability of Developing or Dying of Cancer Software, Version 6.7.3 Statistical Research and Applications Branch, National Cancer Institute, 2015.

Graph 5


Estimated Cancer Deaths in the US in 2016
Males
314,290
Females
281,400
Lung & bronchus 27%
Prostate 8%
Colon & rectum 8%
Pancreas 7%
Liver & intrahepatic bile duct 6%
Leukemia 4%
Esophagus 4%
Urinary bladder 4%
Non-Hodgkin lymphoma 4%
Brain & other nervous system 3%
All other sites 24%
26% Lung & bronchus
14% Breast
8% Colon & rectum
7% Pancreas
5% Ovary
4% Uterine corpus
4% Leukemia
3% Liver & intrahepatic bile duct
3% Non-Hodgkin lymphoma
2% Brain & other nervous system
24% All other sites

Graph 6



Centers for Disease Control, 2018, www.cdc.gov

Graph 7

American Cancer Society Recommendations for the Early Detection of Cancer in Average-risk Asymptomatic People*

Cancer Site	Population	Test or Procedure	Recommendation
Breast	Women, ages 40-54	Mammography	Women should undergo regular screening mammography starting at age 45. Women ages 45 to 54 should be screened annually. Women should have the opportunity to begin annual screening between the ages of 40 and 44.
	Women, ages 55+		Transition to biennial screening, or have the opportunity to continue annual screening. Continue screening as long as overall health is good and life expectancy is 10+ years.
Cervix	Women, ages 21-29	Pap test	Screening should be done every 3 years with conventional or liquid-based Pap tests.
	Women, ages 30-65	Pap test & HPV DNA test	Screening should be done every 5 years with both the HPV test and the Pap test (preferred), or every 3 years with the Pap test alone (acceptable).
	Women, ages 66+	Pap test & HPV DNA test	Women ages 66+ who have had ≥3 consecutive negative Pap tests or ≥2 consecutive negative HPV and Pap tests within the past 10 years, with the most recent test occurring in the past 5 years should stop cervical cancer screening.
	Women who have had a total hysterectomy		Stop cervical cancer screening.
Colorectal†	Men and women, ages 50+	Guaiac-based fecal occult blood test (gFOBT) with at least 50% sensitivity or fecal immunochemical test (FIT) with at least 50% sensitivity, **OR**	Annual testing of spontaneously passed stool specimens. Single stool testing during a clinician office visit is not recommended, nor are "throw in the toilet bowl" tests. In comparison with guaiac-based tests for the detection of occult blood, immunochemical tests are more patient-friendly and are likely to be equal or better in sensitivity and specificity. There is no justification for repeating FOBT in response to an initial positive finding.
		Stool DNA test, **OR**	Every 3 years
		Flexible sigmoidoscopy (FSIG), **OR**	Every 5 years alone, or consideration can be given to combining FSIG performed every 5 years with a highly sensitive gFOBT or FIT performed annually.
		Double-contrast barium enema, **OR**	Every 5 years
		Colonoscopy, **OR**	Every 10 years
		CT Colonography	Every 5 years
Endometrial	Women at menopause		Women should be informed about risks and symptoms of endometrial cancer and encouraged to report unexpected bleeding to a physician.
Lung	Current or former smokers ages 55-74 in good health with 30+ pack-year history	Low-dose helical CT (LDCT)	Clinicians with access to high-volume, high-quality lung cancer screening and treatment centers should initiate a discussion about annual lung cancer screening with apparently healthy patients ages 55-74 who have at least a 30 pack-year smoking history, and who currently smoke or have quit within the past 15 years. A process of informed and shared decision making with a clinician related to the potential benefits, limitations, and harms associated with screening for lung cancer with LDCT should occur before any decision is made to initiate lung cancer screening. Smoking cessation counseling remains a high priority for clinical attention in discussions with current smokers, who should be informed of their continuing risk of lung cancer. Screening should not be viewed as an alternative to smoking cessation
Prostate	Men, ages 50+	Prostate-specific antigen test with or without digital rectal examination	Men who have at least a 10-year life expectancy should have an opportunity to make an informed decision with their health care provider about whether to be screened for prostate cancer, after receiving information about the potential benefits, risks, and uncertainties associated with prostate cancer screening. Prostate cancer screening should not occur without an informed decision-making process.

CT-Computed tomography. *All individuals should become familiar with the potential benefits, limitations, and harms associated with cancer screening. †All positive tests (other than colonoscopy) should be followed up with colonoscopy.

National Comprehensive Cancer Network®

NCCN Guidelines Version 3.2017 Table of Contents
Survivorship

NCCN Guidelines Index
Table of Contents
Discussion

Clinical Trials: NCCN believes that the best management for any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

To find clinical trials online at NCCN Member Institutions, click here: nccn.org/clinical_trials/physician.html.

NCCN Categories of Evidence and Consensus: All recommendations are category 2A unless otherwise indicated.

See NCCN Categories of Evidence and Consensus.

Pre-Operative Breast Cancer Evaluation

Patient's Name_____Age/Sex_____DOB _____

Referring Physician_____Onset Date_____Eval Date_____

Medical Dx_____Treatment Dx ICD-10_____

Surgery Scheduled For: _____

SUBJECTIVE EXAM:

Medical History:

_____

_____

Surgical History:

_____

_____

Chief Concerns/Hx/Onset:_____

_____

Medications:

_____

_____

Allergies:

_____

Assistive Device:_____Occupation/Activity: _____

Hand Dominance_____Type of Residence/Stairs: _____

Support Available: _____

Patient's Goals:

_____

_____

_____

Precautions/Contraindications:

_____

Numbness/Tingling/Altered
Sensation:_____

Any pain/discomfort: Yes No

Pain: 0 1 2 3 4 5 6 7 8 9 10

__Superficial Deep Tingling/Numb Shooting Throbbing
__Dull __Sharp __Aching Continuous Intermittent
__Other_____

Comments: _____

Any prior infections: Yes No Location_____

Body Image Concerns:

_____
_____
_____

Cognitive Concerns:

_____
_____
_____

Distress/Depression/Anxiety:

_____
_____
_____

Spiritual Needs:

_____
_____
_____

Cultural Considerations:

_____
_____

OBJECTIVE EXAM:

Cognition and Learning Preferences:

Alert and Oriented to: Person Time Place

Follow Commands: 1-step 2-step 3 or more steps

Understands and can apply basic information: Yes No

Able to actively participate and follow through: Yes No

Learning barriers: Vision Hearing Unable to read Unable to understand

Language:_____

Other_____

How does patient learn best: Pictures Reading Listening Demonstration

Other _____

Systems Review:

Cardiovascular/Pulmonary: ___impaired ____not impaired _____

Integumentary: ___impaired ____not impaired _____

Musculoskeletal: ___impaired ____not impaired _____

Neuromuscular: ___impaired ____not impaired _____

Skeletal ___impaired ____not impaired _____

Patient Photos Taken with Signed Consent:_____yes_____no photos taken

Circumferential Measurements: See attached sheet.

Grip Strength in pounds: R_____ L _____

Vitals: Heart Rate:_____ BP:____/____Oxygen Sats:_____Weight: _____

Posture/Gross Symmetry: _____

ROM: AROM/AAROM

UPPER EXTREMITY	R	L
Shoulder		
Elbow		
Wrist		
Fingers		

Comments:_____

Muscle Strength

UPPER EXTREMITY	R	L
Shoulder		
Elbow		
Wrist		
Hand		

Comments:_____

Functional Activities: ADLs/IADLs

Key: **I**ndependent **Mod**ified **Ind**ependent **S**tand-**B**y **A**ssistance
Contact **G**uard **A**ssistance **Min**imum **A**ssistance **Mod**erate **A**ssistance
Maximum **A**ssistance

Grooming_____ Reaching top cabinets _____

Bathing UE _____ Reaching low cabinets _____

Bathing LE _____ Carry laundry baskets _____

Dressing UE _____ Housekeeping _____

Dressing LE _____ Shopping _____

Closures _____ Yard Work _____

Comments:_____

Mobility Key: **I**ndependent **Mod**ified **Ind**ependent **S**tand-**B**y **A**ssistance
Contact **G**uard **A**ssistance **Min**imum **A**ssistance
Moderate **A**ssistance **Max**imum **A**ssistance

Regular exercises _____ Leisure activities: _____

Assessment_____

Plan of Care

_____

_____

_____

Patient agreeable to POC: Yes No _____

Rehab Potential: Good____ Fair____ Poor____

Goals and plan discussed with patient/family: Yes____ No____

Time In:_____Time Out: _____

Therapist's Signature_____Date_____

Physician's Signature_____Date_____

AOTA OCCUPATIONAL PROFILE TEMPLATE

"The occupational profile is a summary of a client's occupational history and experiences, patterns of daily living, interests, values, and needs" (AOTA, 2014, p. S13). The information is obtained from the client's perspective through both formal interview techniques and casual conversation and leads to an individualized, client-centered approach to intervention.

Each item below should be addressed to complete the occupational profile. Page numbers are provided to reference a description in the *Occupational Therapy Practice Framework: Domain and Process, 3rd Edition* (AOTA, 2014).

Client /Date:

Client Report	Reason the client is seeking service and concerns related to engagement in occupations	Why is the client seeking service, and what are the client's current concerns relative to engaging in occupations and in daily life activities? (This may include the client's general health status.)	
	Occupations in which the client is successful (p. S5)	In what occupations does the client feel successful, and what barriers are affecting his or her success?	
	Personal interests and values (p. S7)	What are the client's values and interests?	
	Occupational history (i.e., life experiences)	What is the client's occupational history (i.e., life experiences)?	
	Performance patterns (routines, roles, habits, & rituals) (p. S8)	What are the client's patterns of engagement in occupations, and how have they changed over time? What are the client's daily life roles? (Patterns can support or hinder occupational performance.)	
	What aspects of the client's environments or contexts does he or she see as:	Supports to Occupational Engagement	Barriers to Occupational Engagement
Environment	Physical (p. S28) (e.g., buildings, furniture, pets)		
	Social (p. S28) (e.g., spouse, friends, caregivers)		
Context	Cultural (p. S28) (e.g., customs, beliefs)		
	Personal (p. S28) (e.g., age, gender, SES, education)		
	Temporal (p. S28) (e.g., stage of life, time, year)		
	Virtual (p. S28) (e.g., chat, email, remote monitoring)		
Client Goals	Client's priorities and desired targeted outcomes: (p. S34)	Consider: occupational performance—improvement and enhancement, prevention, participation, role competence, health and wellness, quality of life, well-being, and/or occupational justice.	

AOTA® The American Occupational Therapy Association, Inc.

Circumferential Measurements:

Date										
Time of Day										
Position										
Measure	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**
Palm										
Wrist										
12 cms										
16 cms										
20 cms										
24 cms										
28 cms										
32 cms										
36 cms										
40 cms										
44 cms										
48 cms										
52 cms										
56 cms										
60 cms										

CONSENT (RELEASE) TO PHOTOGRAPH

I,_____, a patient at hereby authorize the attending Therapist or other designated person(s) to take:

Photographs of appropriate parts of my body for (specify):

a. To provide visual demonstration of the progress being made.
b. Document treatment outcomes in a pictorial fashion.
c. To use the pictures for future purposes to include education and/or marketing for patients, physicians, therapists, and students.

I understand that any photographs taken will be placed in and remain part of my medical record.

I waive any and all rights I may have to any claims for payment in connection with any use of said photographs.

I release from any and all liability associated with the use or reuse of said photographs or inadvertent revelation of identifying information or images.

I understand I may withdraw this consent in writing at any time; however, it will not have any effect on any actions taken prior to receiving the revocation.

I understand that my medical care is not dependent upon me signing this consent and that I may refuse to have my photographs taken.

I have read the content of this consent/release. I have been given the opportunity to ask, questions and all of my questions have been answered to my satisfaction. I fully understand the contents of this consent/release. This consent/release shall be binding upon me, my heirs and legal representatives.

Patient's Signature _____ Date _____
Legally Authorized Party _____ Date _____

Print Name of Legally Authorized Party _____

Address_____
Phone number _____
Reason for Authority _____
Relationship _____

Witness Signature _____

Date _____

BREAST-Q™
MASTECTOMY MODULE (PREOPERATIVE) 1.0

After reading each question, please circle the number in the box that best describes your situation. If you are unsure how to answer a question, choose the answer that comes closest to how you feel. Please answer all questions.

1. With your breast area in mind, in the past 2 weeks, how satisfied or dissatisfied have you been with:

		Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied
a.	How you look in the mirror clothed?	1	2	3	4
b.	How comfortably your bras fit?	1	2	3	4
c.	Being able to wear clothing that is more fitted?	1	2	3	4
d.	How you look in the mirror unclothed?	1	2	3	4

2. With your breast area in mind, in the past 2 weeks, how often have you felt:

		None of the time	A little of the time	Some of the time	Most of the time	All of the time
a.	Confident in a social setting?	1	2	3	4	5
b.	Emotionally able to do the things that you want to do?	1	2	3	4	5
c.	Emotionally healthy?	1	2	3	4	5
d.	Of equal worth to other women?	1	2	3	4	5
e.	Self-confident?	1	2	3	4	5
f.	Feminine in your clothes?	1	2	3	4	5
g.	Accepting of your body?	1	2	3	4	5
h.	Normal?	1	2	3	4	5
i.	Like other women?	1	2	3	4	5
j.	Attractive?	1	2	3	4	5

Please check that you have answered all the questions before going on to the next page

3. In the past 2 weeks, how often have you experienced:

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. Neck pain?	1	2	3	4	5
b. Upper back pain?	1	2	3	4	5
c. Shoulder pain?	1	2	3	4	5
d. Arm pain?	1	2	3	4	5
e. Rib pain?	1	2	3	4	5
f. Pain in the muscles of your chest?	1	2	3	4	5
g. Difficulty lifting or moving your arms?	1	2	3	4	5
h. Difficulty sleeping because of discomfort in your breast area?	1	2	3	4	5
i. Tightness in your breast area?	1	2	3	4	5
j. Pulling in your breast area?	1	2	3	4	5
k. Nagging feeling in your breast area?	1	2	3	4	5
l. Tenderness in your breast area?	1	2	3	4	5
m. Sharp pains in your breast area?	1	2	3	4	5
n. Shooting pains in your breast area?	1	2	3	4	5
o. Aching feeling in your breast area?	1	2	3	4	5
p. Throbbing feeling in your breast area?	1	2	3	4	5

Please check that you have answered all the questions before going on to the next page

4. Thinking of your sexuality, how often do you generally feel:

	None of the time	A little of the time	Some of the time	Most of the time	All of the time	Not Applicable
a. Sexually attractive in your clothes?	1	2	3	4	5	N/A
b. Comfortable/at ease during sexual activity?	1	2	3	4	5	N/A
c. Confident sexually?	1	2	3	4	5	N/A
d. Satisfied with your sex-life?	1	2	3	4	5	N/A
e. Confident sexually about how your breast area looks when unclothed?	1	2	3	4	5	N/A
f. Sexually attractive when unclothed?	1	2	3	4	5	N/A

Please check that you have answered all the questions

Prevention and Control of Upper Extremity Lymphedema

Check all areas of your arm(s) everyday for signs of problems such as swelling, hardness, a rash, itching, redness, pain, areas that feel hot, sores or cuts. Report concerns to your doctor.

Know the Early Signs of Edema

Your arm(s) feels tight and heavy.
Your jewelry and clothing feel tight.
Measure your arm(s) and compare to your baseline measurements

Protect Your Arm from Injury and Infection

Keep your arm(s) as clean as possible. Bath with a mild soap and water and dry Gently. Take care of your fingernails and avoid cutting your cuticles.

Protect your skin.

- Use a low pH lotion to keep your skin from drying or cracking.
- Use sunscreen and insect repellent when you are outside.
- Shave with an electric razor.
- Wear gloves when gardening, doing housework or using the oven.
- Avoid extreme hot or cold such as ice packs, heating pads and hot tubs.

Don't overtire your arm(s).

- Avoid vigorous repetitive movements such as scrubbing.
- Limit lifting to no more than 5 pounds.
- Don't carry heavy over-the-shoulder bags on your affected side(s).

Elevate your arm(s) above the level of your heart whenever possible, particularly at night.

Avoid have your blood pressure taken in the affected arm(s).

Wear loose jewelry and clothes without tight bands.

Do not allow an injection, blood draw or acupuncture in the affected arm(s)

You can order a lymphedema alert bracelet from the National Lymphedema Network (http://www.lymphnet.org or 1-800-541-3259).

Occupational Therapy TOOLKIT

Deep Breathing Exercise

Deep breathing is combining pursed lip breathing and diaphragmatic breathing.

This exercise will help maintain the normal movement of your chest, making it easier for your lungs to expand. Continue these deep-breathing exercises indefinitely.

Perform this exercise 5-6 times a day. Take 5-6 deep breathes each session.

Instructions:

1. Sit in a comfortable position with your back supported or resting comfortably in bed in a semi-reclined position.
2. Place one hand on your stomach above the naval. Place your other hand on your chest.
3. Locate your diaphragm with a quick "sniff" or a few short pants.
4. Exhale slowly through pursed lips and gently push in with the hand that is on the stomach. The hand on your chest should be still.
5. Inhale deeply through your nose and allow the hand on your stomach to rise with the expanding diaphragm. The hand on your chest should be still.

Inpatient/Post-Operative
Breast Cancer Evaluation

Patient's Name_____Age/Sex_____
DOB _____
Referring Physician_____Onset Date_____
Eval Date_____
Medical Dx_____Treatment Dx ICD-10 _____
Next MD Appt: _____

SUBJECTIVE EXAM:
Medical History:

Surgical History:

Chief Complaints/Hx/Onset:_____

Medications:

Allergies:

Assistive Device:_____Occupation/Activity: _____
Hand Dominance_____Type of Residence/Stairs: _____
Support Available: _____
Patient's Goals:

Precautions/Contraindications:

Numbness/Tingling/Altered Sensation:_____
Any pain/discomfort: Yes No
Pain: 0 1 2 3 4 5 6 7 8 9 10
__Superficial Deep Tingling/Numb Shooting Throbbing
__Dull __Sharp Aching __Continuous __Intermittent
__Other_____

Comments:

Body Image Concerns:

Cognitive Concerns:

Distress/Depression/Anxiety:

Spiritual Needs:

OBJECTIVE EXAM:

Cognition and Learning Preferences:

Alert and Oriented to: Person Time Place

Follow Commands: 1-step 2-step 3 or more steps

Understands and can apply basic information: Yes No

Able to actively participate and follow through: Yes No

Learning barriers: Vision Hearing Unable to read

Unable to understand Language_____

Other_____

How does patient learn best: Pictures Reading Listening

Demonstration Other_____

Systems Review:

Cardiovascular/Pulmonary: ___impaired ____not impaired

Integumentary: ___impaired ____not impaired

Musculoskeletal: ___impaired ____not impaired

Neuromuscular: ___impaired ____not impaired

Skeletal ___impaired ____not impaired

Vitals: Heart Rate: _____ BP:____/____Oxygen Sats: _____ Weight: _____

Posture/Gross Symmetry: _____

ROM: AROM/AAROM

UPPER EXTREMITY	R	L
Shoulder		
Elbow		
Wrist		
Fingers		

Comments:_____

Functional Activities: ADLs/IADLs

Key: **I**ndependent **Mod**ified **Ind**ependent **S**tand-**B**y **A**ssistance
Contact **G**uard **A**ssistance **Min**imum **A**ssistance
Moderate **A**ssistance **Max**imum **A**ssistance

Grooming _____
Bathing UE _____
Bathing LE _____
Dressing UE _____
Dressing LE _____
Closures _____

Comments:_____

_____

Mobility Key: **I**ndependent **Mod**ified **Ind**ependent **S**tand-**B**y **A**ssistance
Contact **G**uard **A**ssistance
Minimum **A**ssistance **Mod**erate **A**ssistance **Max**imum **A**ssistance

In and out of bed _____
On and off toilet _____
Sit to stand _____
Walking _____
Climbing stairs _____

Assessment_____

_____

_____

_____

Plan of Care

Goals and plan discussed with patient/family: Yes____ No____

Time In:_____Time Out: _____

Therapist's Signature_____Date_____

Physician's Signature_____Date_____

Occupational Therapy TOOLKIT

Mastectomy Exercises

Patient Name: _____

Date: _____

Therapist Name: _____

Phone number: (_____)_____

Exercise Guidelines:

Perform the checked exercises _____ time(s) per day, _____ days a week.

Exercise slowly and gently.

Remember to maintain proper posture with each exercise.

Don't hold your breath during any of the exercises. This could affect your blood pressure. Count out loud if needed.

If you experience chest pain, unusual shortness of breath, dizziness, nausea, blurred vision or other unusual symptoms while exercising, stop immediately and call 911.

Muscle soreness lasting a few days and slight fatigue are normal after exercising.

Exhaustion, sore joints, and painful muscle pulls are not normal. If you experience these symptoms, do not resume exercising until you talk with your therapist.

Additional Instructions:

_____

_____

_____

_____

_____

_____

Outpatient Post-Operative Breast Cancer Evaluation

Patient's Name_____Age/Sex_____DOB_____
Referring Physician_____Onset Date_____
Eval Date_____
Medical Dx_____Treatment Dx ICD10_____
Next MD Appt: _____

SUBJECTIVE EXAM:

Medical History:

Surgical History:

Chief Complaints/Hx/Onset:_____

Medications:

Allergies:

Assistive Device: _____
Occupation/Activity:

Hand Dominance_____Type of Residence/Stairs:

Support Available:

Patient's Goals:

Precautions/Contraindications:

Numbness/Tingling/Altered
Sensation:_____
Any pain/discomfort: Yes No
Pain: 0 1 2 3 4 5 6 7 8 9 10

__Superficial Deep Tingling/Numb Shooting Throbbing
__Dull __Sharp __Aching Continuous Intermittent
__Other_____
Comments:

Overall Condition: Improving Worsening Stable
Any prior infections: Yes No
Location_____
Body Image Concerns:

Cognitive Concerns:

Distress/Depression/Anxiety:

Spiritual Needs:

OBJECTIVE EXAM:

Cognition and Learning Preferences:

Alert and Oriented to: Person Time Place

Follow Commands: 1-step 2-step 3 or more steps

Understands and can apply basic information: Yes No

Able to actively participate and follow through: Yes No

Learning barriers: Vision Hearing Unable to read

Unable to understand Language

Other_____

How does patient learn best: Pictures Reading Listening

Demonstration Other _____

Systems Review:

Cardiovascular/Pulmonary: ___impaired ____not impaired

Integumentary: ___impaired ____not impaired

Musculoskeletal: ___impaired ____not impaired

Neuromuscular: ___impaired _____not impaired

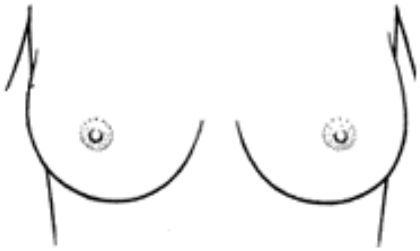
Skeletal ___impaired _____not impaired

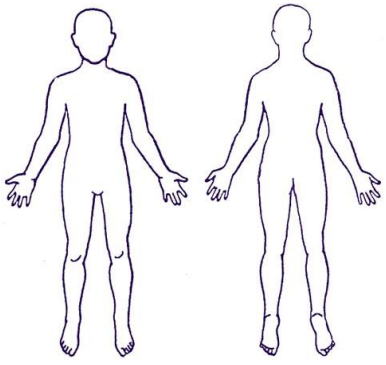
Skin Condition

SKIN CONDITION	YES	NO	Comment/Location
Ulcerations/wounds			
Contracture			
Dryness			
Other Lesions			
Lipodermatosclerosis			
Edema (Pitting/Non-Pitting)			
Pitting (degree)			
Hair Growth			
Stemmer Sign			
Scars			
Other:			

Patient Photos Taken with Signed Consent:_____yes_____no photos taken

Scar Locations:





Circumferential Measurements: See attached sheet.

Grip Strength in pounds: R_____ L _____

Vitals: Heart Rate: _____ BP:____/_____ Oxygen Sats: _____ Weight: _____
Posture/Gross Symmetry:

Balance:_____

Gait:_____

ROM: AROM/AAROM

UPPER EXTREMITY	R	L
Shoulder		
Elbow		
Wrist		
Fingers		

Comments:_____

_____

Muscle Strength

UPPER EXTREMITY	R	L
Shoulder		
Elbow		
Wrist		
Hand		

Comments:_____

_____

Functional Activities: ADLs/IADLs

Key: **I**ndependent **Mod**ified **Ind**ependent **S**tand-**B**y **A**ssistance

Contact **G**uard **A**ssistance **Min**imum **A**ssistance

Moderate **A**ssistance **Max**imum **A**ssistance

Grooming_____ Reaching top cabinets _____

Bathing UE _____ Reaching low cabinets _____

Bathing LE _____ Carry laundry baskets _____

Dressing UE _____ Housekeeping _____

Dressing LE _____ Shopping _____

Closures _____ Yard Work _____

Comments:_____

_____

Mobility Key: **I**ndependent **Mod**ified **Ind**ependent **S**tand-**B**y **A**ssistance

Contact **G**uard **A**ssistance

Minimum **A**ssistance **Mod**erate **A**ssistance **Max**imum **A**ssistance

In and out of bed _____ Walking _____

On and off toilet _____
Sit to stand _____
In and out of car _____

Climbing stairs _____
Regular exercises _____
Leisure activities _____

Assessment_____

_____

_____

_____

_____

_____

_____

_____

Plan of Care

Short Term Goals_____Weeks

Long Term Goals_____Weeks

Plan: Frequency _____ Duration_____weeks
Patient agreeable to POC: Yes No
Possible barriers to treatment: _____

Interventions:
_____Therapeutic exercises: stretching strengthening lymphatic
_____Wound care education
_____Scar management
_____Patient/Caregiver/Family education
_____Precautions
_____Other: _____

Rehab Potential: Good_____ Fair_____ Poor_____

Goals and plan discussed with patient/family: Yes_____ No_____

Time In:_____Time Out: _____

Outpatient Certification from:_____to_____

Therapist's Signature_____Date_____

Rehab MD OP Certification Statement: I certify that the program outlined above is provided under my supervision and is required for this patient. Care plan was developed by the therapist, discussed with the patient, and will be reviewed every 90 days.

Physician's Signature_____
Date_____

DAILY TREATMENT RECORD

Diagnosis:_____ **Re-eval date:**_____
Date:_____

Precautions: □ Falls □ Lymphedema

□ Other:_____

Subjective:

_____

_____

Patient reported a change in: □ medication □ allergy □ condition:
_____

PAIN:_____/10 □ decreased □ increased □ no change

Affected by: _____

Treatment Interventions: □

STM x_____min to: □ decrease pain □ decrease soft tissue restriction □ i

□ Therapeutic Exercise x_____min:

_____

To improve: □ strength □ ROM □ motor control □ endurance □ flexibility
□ see flow sheet

□ NLN Risk Reduction □ NLN Exercise □ instruct on don/doffing of garments
□ instruct on garment care, wearing schedule or adjustment

Other:_____

_____

□ Neuromuscular Re-education x_____min to: □ facilitate normalized resting posture on □ involved side □ non-involved side

□ to decrease substitution and normalize muscle recruitment patterns for decreased pain and functional ROM

□ balance □ coordination □ proprioception for sitting / standing activities

_____

OBJECTIVE FINDINGS:

_____

_____

_____

_____

_____

□ Routine Measurements (see measurement flow sheet)

□ Photos (with signed consent on file) – see attached

Assessment:

_____

_____

_____

_____

The patient's progress toward established goals is: excellent good fair poor

Patient requires skilled therapy services for □ CDT – intensive phase □ Modified CDT □ early intervention lymphedema management □ Cording treatment □ pain control □ ROM □ Strengthening □ Functional improvement

P: □ D/C Therapy □ Next Visit:

Therapist:

Occupational Therapy
Outpatient Lymphedema Evaluation

Patient's Name_____Age/Sex_____DOB_____
Referring Physician_____Onset Date_____
Eval Date_____
Medical Dx_____Treatment Dx ICD-10_____
Next MD Appt: _____

SUBJECTIVE EXAM:
Medical History:

Surgical History:

Chief
Complaints/Hx/Onset:_____

Medications:

Allergies: _____
Assistive Device: _____
Occupation/Activity:

Previous Treatment for Lymphedema

Family History of Lymphedema:

Hand Dominance_____Type of Residence/Stairs:

Support Available:

Patient's Goals:

Precautions/Contraindications:

Numbness/Tingling/Altered
Sensation:_____
Any pain/discomfort: Yes No
Pain: 0 1 2 3 4 5 6 7 8 9 10
__Superficial Deep Tingling/Numb Shooting Throbbing
__Dull Sharp Aching Continuous Intermittent
__Other_____
Comments:

_____
Overall Condition: Improving Worsening Stable
Any prior infections: Yes No
Location_____
Symptoms of Lymphedema relieved by, if yes please circle:
Elevation Exercise Massage Garment Diuretics Compression Pump
Unable to relieve symptoms
Body Image Concerns:

_____
_____
Cognitive Concerns:

_____
_____
Distress/Depression/Anxiety:

_____
_____
Spiritual Needs:

_____
_____

OBJECTIVE EXAM:

Cognition and Learning Preferences:

Alert and Oriented to: Person Time Place

Follow Commands: 1-step 2-step 3 or more steps

Understands and can apply basic information: Yes No

Able to actively participate and follow through: Yes No

Learning barriers: Vision Hearing Unable to read

Unable to understand Language

Other_____

How Hoes patient learn best: Pictures Reading Listening

Demonstration

Other _____

Systems Review:

Cardiovascular/Pulmonary: ___impaired _____not impaired

Integumentary: ___impaired _____not impaired

Musculoskeletal: ___impaired _____not impaired

Neuromuscular: ___impaired _____not impaired

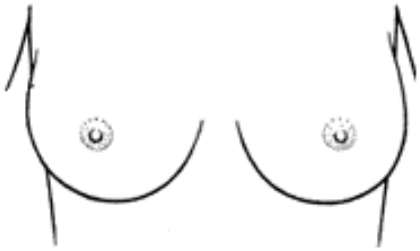
Skeletal ___impaired _____not impaired

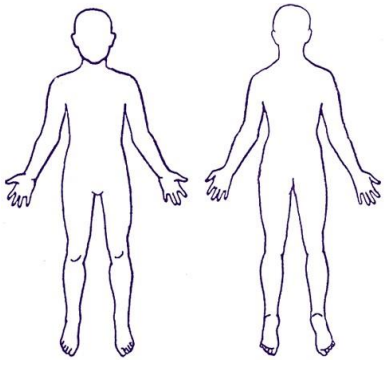
Skin Condition

SKIN CONDITION	YES	NO	Comment/Location
Ulcerations/wounds			
Contracture			
Dryness			
Other Lesions			
Lipodermatosclerosis			
Edema (Pitting/Non-Pitting)			
Pitting (degree)			
Hair Growth			
Stemmer Sign			
Scars			
Other:			

Patient Photos Taken with Signed Consent:_____yes_____no photos taken

Scar Locations:





Circumferential Measurements: See attached sheet.

Grip Strength in pounds: R_____ L _____

Vitals: Heart Rate: _____ BP:____/_____ Oxygen Sats: _____
Weight: _____

Posture/Gross Symmetry: _____
Balance:_____
Gait:_____

ROM: AROM/AAROM

UPPER EXTREMITY	R	L
Shoulder		
Elbow		
Wrist		
Fingers		

Comments:_____

Muscle Strength

UPPER EXTREMITY	R	L
Shoulder		
Elbow		
Wrist		
Hand		

Comments:_____

Functional Activities: ADLs/IADLs

Key: **I**ndependent **Mod**ified **Ind**ependent **S**tand-**B**y **A**ssistance
Contact **G**uard **A**ssistance **Min**imum **A**ssistance **Mod**erate **A**ssistance
Maximum **A**ssistance

Grooming_____ Reaching top cabinets _____
Bathing UE _____ Reaching low cabinets _____
Bathing LE _____ Carry laundry baskets _____
Dressing UE _____ Housekeeping _____
Dressing LE _____ Shopping _____
Closures _____ Yard Work _____

Comments:_____

_____

Mobility Key: **I**ndependent **Mod**ified **Ind**ependent

Stand-**B**y **A**ssistance **C**ontact **G**uard **A**ssistance **Min**imum **A**ssistance

Moderate **A**ssistance **Max**imum **A**ssistance

In and out of bed	_____	Walking	_____
On and off toilet	_____	Climbing stairs	_____
Sit to stand	_____	Regular exercises	_____
In and out of car	_____	Leisure activities	_____

Assessment_____

_____

_____

_____

_____

_____

_____

_____

Plan of Care

Short Term Goals_____Weeks

N/A Yes

1_____ _____ Reduce measurements difference from_____% to _____ %.

2_____ _____ Improve quality tissue with reduction of fibrosis to improve health of tissue

3_____ _____ Improve AROM of_____UE/LE as follows

_____

4_____ _____ Improve strength of_____UE/LE as follows

_____

5_____ _____ Independent with skin care to reduce risks of infection

6_____ _____ Reduce pain to_____/10 in_____UE/LE

7 _____Demonstrates_____% understanding of lymphedema/treatment /HEP

8_____ _____ Demonstrates_____% adherence to lymphedema precautions
9_____ _____ Other functional goals
_____

_____

Long Term Goals_____Weeks

N/A Yes
1_____ _____Reduce measurement difference from_____% to_____%
2_____ _____Resolution of pitting edema for improved health of tissue/reduce risk of infections
3_____ _____ Independent with self-bandaging
4_____ _____ Patient to be at_____% of functional use of_____UE/LE
5 _____Patient will manage lymphedema with_____% independence
6_____ _____ Patient will follow HEP with_____% independence
7_____ _____ Patient to be able to don/doff compression garments with _____% independence
8_____ _____ Other functional goals_____

Before Initiating Treatment patient will need to do the following:
__arrange for assistance with home program __obtain reliable transportation
__arrange work schedule/FMLS __obtain further medical clearance
__obtain bandage supplies

Plan: Frequency _____ Duration_____weeks Patient agreeable to POC: Yes No
Possible barriers to treatment:
_____

Interventions:
_____Manual Lymphatic drainage (MLD)
_____Compression bandaging
_____Self-care training: bandaging skin care self-massage
_____Therapeutic exercises: stretching strengthening lymphatic
_____Wound care education
_____Compression garment
_____Don/doff of garment
_____Scar management
_____Patient/Caregiver/Family education
_____Precautions
_____Other: _____

Rehab Potential: Good____ Fair____ Poor____

Goals and plan discussed with patient/family: Yes____ No____

Time In:_____Time Out: _____

Outpatient Certification from:_____to_____

Therapist's Signature_____Date_____

Rehab MD OP Certification Statement: I certify that the program outlined above is provided under my supervision and is required for this patient. Care plan was developed by the therapist, discussed with the patient, and will be reviewed every 90 days.

Physician's Signature_____Date_____

DAILY TREATMENT RECORD

Diagnosis:_____ **Re-eval date:**_____
Date:_____

Precautions: □ Falls □ Lymphedema □
Other:_____

Subjective:

_____

_____

_____

Patient reported a change in: □ medication □ allergy □ condition:

_____

PAIN:_____/10 □ decreased □ increased □ no change

Affected by: _____

Treatment Interventions: □

□ Manual Therapy: MLD x_____min to decongest affected region and promote improved lymphatic drainage to non-affected regions

STM x_____min to: □ decrease pain □ decrease soft tissue restriction □ improve ROM □ improve tissue extensibility

Compression Bandaging x_____min to □ prevent re-accumulation of edema □ decrease limb size □ decrease fibrosis

□ Therapeutic Exercise x_____min:

_____

To improve: □ strength □ ROM □ motor control □ endurance □ flexibility
□ see flow sheet

□ Self Care Mgt x_____min to learn: □ bandage management □ meticulous skin & nail care □ self-bandaging □ self-MLD □ family training

□ NLN Risk Reduction □ NLN Exercise □ instruct on don/doffing of garments □ instruct on garment care, wearing schedule or adjustment

□ Other:_____

□ Orthotic Fit/Training x_____min to measure for garments:

_____

□ Neuromuscular Re-education x_____min to: □ facilitate normalized resting posture on □ involved side □ non-involved side

□ to decrease substitution and normalize muscle recruitment patterns for decreased pain and functional ROM

□ balance □ coordination □ proprioception for sitting / standing activities

_____

□ **OBJECTIVE FINDINGS**:

_____

_____

_____

_____

_____

□ Routine Measurements (see measurement flow sheet) □ Photos (with signed consent on file) – see attached

Assessment:

_____

_____

_____

_____

_____

The patient's progress toward established goals is: excellent good fair poor

Patient requires skilled therapy services for □ CDT – intensive phase □ Modified CDT □ early intervention lymphedema management

□ Cording treatment □ pain control □ ROM □ Strengthening □ Functional improvement

P: □ D/C Therapy □ Next Visit:

Therapist:

MASTECTOMY MODULE (POSTOPERATIVE) 2.0

After reading each question, please circle the number in the box that best describes your situation. If you are unsure how to answer a question, choose the answer that comes closest to how you feel. Please answer all questions.

1. With your breast area in mind, in the past 2 weeks, how satisfied or dissatisfied have you been with:

		Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied
a.	How you look in the mirror clothed?	1	2	3	4
b.	How comfortably your bras fit?	1	2	3	4
c.	Being able to wear clothing that is more fitted?	1	2	3	4
d.	How you look in the mirror unclothed?	1	2	3	4

2. With your breast area in mind, in the past 2 weeks, how often have you felt:

		None of the time	A little of the time	Some of the time	Most of the time	All of the time
a.	Confident in a social setting?	1	2	3	4	5
b.	Emotionally able to do the things that you want to do?	1	2	3	4	5
c.	Emotionally healthy?	1	2	3	4	5
d.	Of equal worth to other women?	1	2	3	4	5
e.	Self-confident?	1	2	3	4	5
f.	Feminine in your clothes?	1	2	3	4	5
g.	Accepting of your body?	1	2	3	4	5
h.	Normal?	1	2	3	4	5
i.	Like other women?	1	2	3	4	5
j.	Attractive?	1	2	3	4	5

Please check that you have answered all the questions before going on to the next page

BREAST-Q™
MASTECTOMY MODULE (POSTOPERATIVE) 2.0

3. In the past 2 weeks, how often have you experienced:

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. Neck pain?	1	2	3	4	5
b. Upper back pain?	1	2	3	4	5
c. Shoulder pain?	1	2	3	4	5
d. Arm pain?	1	2	3	4	5
e. Rib pain?	1	2	3	4	5
f. Pain in the muscles of your chest?	1	2	3	4	5
g. Difficulty lifting or moving your arms?	1	2	3	4	5
h. Difficulty sleeping because of discomfort in your breast area?	1	2	3	4	5
i. Tightness in your breast area?	1	2	3	4	5
j. Pulling in your breast area?	1	2	3	4	5
k. Nagging feeling in your breast area?	1	2	3	4	5
l. Tenderness in your breast area?	1	2	3	4	5
m. Sharp pains in your breast area?	1	2	3	4	5
n. Shooting pains in your breast area?	1	2	3	4	5
o. Aching feeling in your breast area?	1	2	3	4	5
p. Throbbing feeling in your breast area?	1	2	3	4	5

Please check that you have answered all the questions before going on to the next page

BREAST-Q™
MASTECTOMY MODULE (POSTOPERATIVE) 2.0

4. Thinking of your sexuality, how often do you generally feel:

		None of the time	A little of the time	Some of the time	Most of the time	All of the time	Not Applicable
a.	Sexually attractive in your clothes?	1	2	3	4	5	N/A
b.	Comfortable/at ease during sexual activity?	1	2	3	4	5	N/A
c.	Confident sexually?	1	2	3	4	5	N/A
d.	Satisfied with your sex-life?	1	2	3	4	5	N/A
e.	Confident sexually about how your breast area looks when unclothed?	1	2	3	4	5	N/A
f.	Sexually attractive when unclothed?	1	2	3	4	5	N/A

5. These questions ask about your breast cancer surgeon. Did you feel that he/she:

		Definitely Disagree	Somewhat Disagree	Somewhat Agree	Definitely Agree
a.	Was professional?	1	2	3	4
b.	Gave you confidence?	1	2	3	4
c.	Involved you in the decision-making process?	1	2	3	4
d.	Was reassuring?	1	2	3	4
e.	Answered all your questions?	1	2	3	4
f.	Made you feel comfortable?	1	2	3	4
g.	Was thorough?	1	2	3	4
h.	Was easy to talk to?	1	2	3	4
i.	Understood what you wanted?	1	2	3	4
j.	Was sensitive?	1	2	3	4
k.	Made time for your concerns?	1	2	3	4
l.	Was available when you had concerns?	1	2	3	4

BREAST-Q™
MASTECTOMY MODULE (POSTOPERATIVE) 2.0

Please check that you have answered all the questions before going on to the next page

6. These questions ask about members of the medical team other than the surgeon (e.g. nurses and other doctors who looked after you in the hospital when you had your mastectomy). Did you feel that they:

		Definitely Disagree	Somewhat Disagree	Somewhat Agree	Definitely Agree
a.	Were professional?	1	2	3	4
b.	Treated you with respect?	1	2	3	4
c.	Were knowledgeable?	1	2	3	4
d.	Were friendly and kind?	1	2	3	4
e.	Made you feel comfortable?	1	2	3	4
f.	Were thorough?	1	2	3	4
g.	Made time for your concerns?	1	2	3	4

7. These questions ask about members of the office staff (e.g. secretaries, office or clinic nurses). Did you feel that they:

		Definitely Disagree	Somewhat Disagree	Somewhat Agree	Definitely Agree
a.	Were professional?	1	2	3	4
b.	Treated you with respect?	1	2	3	4
c.	Were knowledgeable?	1	2	3	4
d.	Were friendly and kind?	1	2	3	4
e.	Made you feel comfortable?	1	2	3	4
f.	Were thorough?	1	2	3	4
g.	Made time for your concerns?	1	2	3	4

Please check that you have answered all the questions

Occupational Therapy TOOLKIT

Stress Management and Relaxation Techniques

What Causes Stress?

- Major events
  Injury, illness, moving, death of someone close to you.

- Everyday life events
  Disagreements, waiting for others, not sleeping well, meeting new people, being late, feeling bored, having too much to do.

Identify the Causes of Your Stress

- Keep a log of stressful events that occur in your life for 2 weeks.

Recognize How Stress Affects You

- Physical signs
  Fatigue, nightmares, tightness of the neck and shoulder muscles, headaches, high blood pressure, digestive problems, chest pain, irregular heartbeat.

- Mental signs
  Memory problems, difficulty making decisions, inability to concentrate, negative thinking, racing thoughts, poor judgment, loss of objectivity.

- Emotional signs
  Restlessness, anxiety, depression, anger and resentment, easily irritated, overwhelmed, lack of confidence, apathy.

- Behavioral signs
  Eating more or less, sleeping too much or too little, nervous habits (e.g. nail biting, pacing), teeth grinding or jaw clenching, losing your temper, overreacting to unexpected problems.

How to Cope with Stress

- Prevent or avoid the situation.

- Change as much of the situation as possible.

- Change your response to the situation.
  Learn to accept what cannot be changed.
  Talk about worries and frustrations.
  Take one thing at a time; learn to prioritize and manage time.

Occupational Therapy TOOLKIT

Stress Management and Relaxation Techniques

Taking Care of Yourself So You Can Handle Stress Better

- Talk to someone about your feelings.
- Eat a well-balanced diet.
- Exercise that includes stretching, strengthening and cardiovascular.
- Get enough sleep.
- Balance self-care and work with recreation.
- Do something nice for yourself every day.

Practice Relaxation and Stress Reduction Activities

- Controlled breathing
- Progressive muscle relaxation
- Guided imagery
- Self-hypnosis
- Meditation
- Prayer
- Tai Chi
- Yoga
- Listening to music.
- Looking at a pleasant scene or piece of art.

Occupational Therapy TOOLKIT

Mastectomy Exercises

☐ **Head Tilt**
Tilt your head toward your shoulder.
Repeat on the other side.

Complete _____ set(s) of _____

☐ **Shoulder Shrug**
Shrug your shoulders and release.

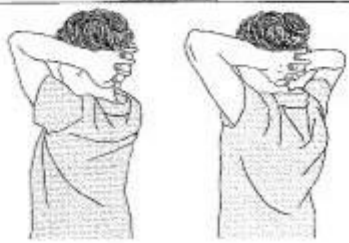
Complete _____ set(s) of _____

☐ **Back Stretch**
Grasp your hands together behind your back. Pull your shoulder blades together and release.

Complete _____ set(s) of _____

☐ **Elbow Spread**
Clasp your hands behind your neck. Bring your elbows together and then spread your elbows apart.

Complete _____ set(s) of _____



Occupational Therapy TOOLKIT

Mastectomy Exercises

☐ **Corner Stretch**
Stand facing a corner. Bend your elbows and put your forearms on the wall. Your elbows should be as close to shoulder height as possible. Move your chest toward the corner.

Complete _____ set(s) of _____

☐ **Wall Walk - Forward**
Stand with your involved arm facing the wall. Walk your fingers up the wall, and then wall them down the wall.

Complete _____ set(s) of _____

☐ **Wall Walk - Side**
Stand with your involved arm next to the wall. Walk your fingers up the wall, and then wall them down the wall.

Complete _____ set(s) of _____

☐ **Shoulder Flexion**
Hold a cane or dowel with your hands at shoulder width apart. Lift the dowel up in front as high as you can.

Complete _____ set(s) of _____

Occupational Therapy TOOLKIT

Mastectomy Exercises

☐ **Shoulder Abduction**
Hold a cane or dowel with your hands at shoulder width apart. Lift the dowel up to the side as high as you can. Repeat to opposite side.

Complete _____ set(s) of _____

☐ **Shoulder Side to Side**
Hold a cane or dowel with your hands at shoulder width apart. Move the dowel from side to side.

Complete _____ set(s) of _____

☐ **Shoulder Extension**
Hold the cane or dowel behind you. Keeping your elbows straight, lift the dowel away from your body.

Complete _____ set(s) of _____

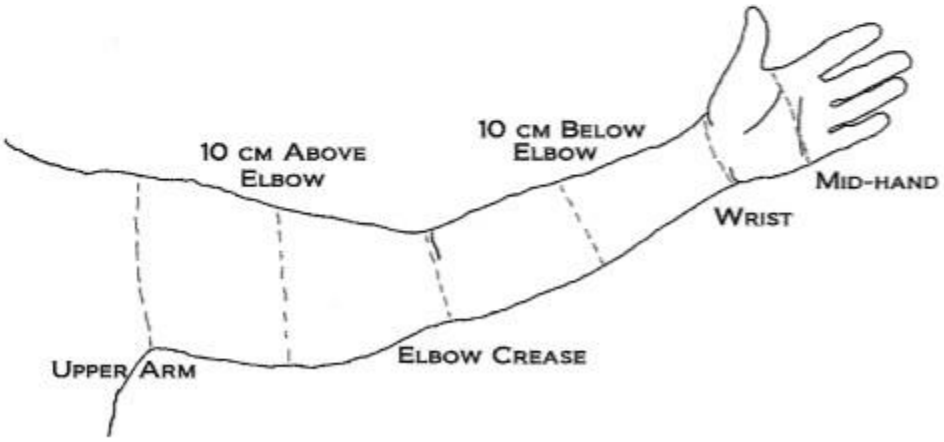
☐ **Shoulder Internal Rotation**
Hold the cane or dowel behind you. Bend your elbows and lift the dowel up your back.

Complete _____ set(s) of _____

Occupational Therapy TOOLKIT

Measuring Your Arm Following Mastectomy

Date							
Upper arm just below the axilla							
10 cm above elbow crease							
Elbow crease							
10 cm below elbow crease							
Wrist							
Mid-hand							



Occupational Therapy TOOLKIT

Energy Conservation

Pace Yourself

1. Allow yourself enough time to complete a task without having to rush.
2. Spread heavy and light tasks throughout the day and week.
3. Don't schedule too many activities in one day.

Plan Ahead and Be Organized

1. Gather all items you will need before you start a task.
2. Keep items organized and within easy reach.

Simplify Your Tasks and Set Realistic Goals

1. Prioritize what activities are most important to you.
2. Don't think you have to do things the same way you've always done them.
3. Ask for help. Divide tasks among family and friends.
4. Use adaptive equipment when needed.
5. Use appliances to do the work for you.

Avoid Fatigue

1. Don't wait until you are tired before you stop and rest.
2. Plan rest periods throughout the day, 5-10 minutes out of every hour.
3. Sit when possible.
4. Use pursed lip breathing
5. Do not plan activities right after a meal. Rest 20 to 30 minutes after each meal.
6. Get a good night's sleep and elevate your head when sleeping.

Avoid Unnecessary Motion

1. Limit the need to bend, reach and twist.
2. Minimize arm movements especially above your shoulder level.
3. Keep your elbows low and close to your body.
4. Support elbows on a surface when working in one place.

Use Good Posture

1. Sit and stand straight.
2. Proper body alignment balances muscles and decreases stress.
3. A stooped posture makes breathing more difficult.

Use Good Body Mechanics

1. Stand close to the object to be moved.
2. Push or pull rather than lift. Slide objects along the counter.
3. Avoid bending, reaching and twisting.
4. Carry items close to the body, keeping your back straight.
5. If you must lift, use your legs muscles rather than your back.

Occupational Therapy TOOLKIT

Good Posture

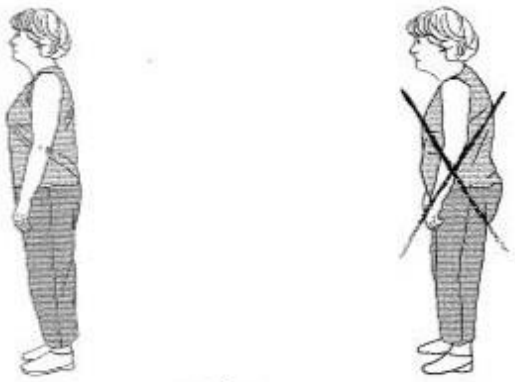
Be aware of your posture during daily activities. Good posture should be a part of all activities to minimize stress to your spine.

Sleeping

- Sleep on a firm mattress. A king or queen size bed allows freedom to change positions.
- Only sleep with one pillow under your head. If you need to elevate your head at night, use a foam wedge.
- When getting out of bed, log roll to one side and sit up, using your arms to help.
- The best position for sleeping is on your side with your knees slightly bent and a pillow placed in between.
- When lying on your back, place one or two pillows under your knees.

Standing

- Stand with knees slightly bent, stomach and buttock muscles tightened.
- When standing, keep activities at a comfortable height.
- Change position frequently.



LLIS Lymphedema Life Impact Scale

version 2

Patient Name _____ **Eval** _____ **10th visit** _____ **20th visit** _____ **30th visit** _____ **D/C** _____

Listed below are symptoms or problems reported by many individuals with lymphedema. Please indicate to what extent these problems associated with your lymphedema has affected you in **the past week**. Circle the number which best describes your symptom level.

I. Physical Concerns (NOTE: If swelling and symptoms are the same in both limbs, rate them the same; otherwise, rate only the worst limb)

1. The amount of pain associated with my lymphedema is:	0 no pain	1	2	3	4 severe pain
2. The amount of limb heaviness associated with my lymphedema is:	0 no heaviness	1	2	3	4 extremely heavy
3. The amount of skin tightness associated with my lymphedema is:	0 no tightness	1	2	3	4 extremely tight
4. The size of my swollen limb(s) seems:	0 normal size	1	2	3	4 extremely large
5. Lymphedema affects the movement of my swollen limb(s):	0 normal movement	1	2	3	4 extremely limited
6. The strength in my swollen limb(s) is:	0 normal strength	1	2	3	4 extremely weak

II. Psychosocial Concerns

7. Lymphedema affects my body image (how I think I look):	0 not at all	1	2	3	4 completely
8. Lymphedema affects my socializing with others.	0 no interference	1	2	3	4 interferes completely

II. Psychosocial Concerns (cont.)

9. Lymphedema affects my intimate relations with spouse or partner (rate 0 if not applicable).	0 no interference	1	2	3	4 interferes completely
10. Lymphedema "gets me down" (i.e., I have feelings of depression, frustration, or anger due to the lymphedema).	0 never	1	2	3	4 constantly
11. I must rely on others for help due to my lymphedema.	0 not at all	1	2	3	4 completely
12. I know what to do to manage my lymphedema.	0 good understanding	1	2	3	4 no understanding

III. Functional Concerns

13. Lymphedema affects my ability to perform self-care activities (i.e., eating, dressing, hygiene).	0 no interference	1	2	3	4 interferes completely
14. Lymphedema affects my ability to perform routine home or work-related activities.	0 no interference	1	2	3	4 interferes completely
15. Lymphedema affects my performance of preferred leisure activities.	0 no interference	1	2	3	4 interferes completely
16. Lymphedema affects the proper fit of clothing/shoes.	0 fits normally	1	2	3	4 unable to wear
17. Lymphedema affects my sleep.	0 no interference	1	2	3	4 interferes completely

IV. Infection Occurrence

18. **In the past year**, I have become ill with an infection in my swollen limb requiring oral antibiotics or hospitalization.	0	1x	2x	3x	4+

1903

Date: ___ / ___ / ___ (month) (day) (year)

Subject's Initials : _____

Study Subject #: _____

PLEASE USE BLACK INK PEN

Study Name: _____

Protocol #: _____

PI: _____

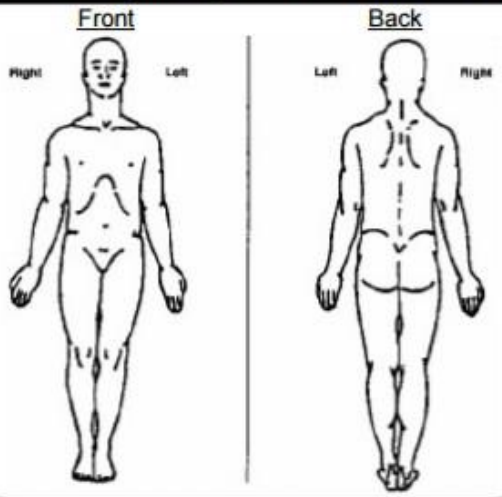
Revision: 07/01/05

Brief Pain Inventory (Short Form)

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

☐ Yes ☐ No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by marking the box beside the number that best describes your pain at its worst in the last 24 hours.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Pain As Bad As You Can Imagine

4. Please rate your pain by marking the box beside the number that best describes your pain at its least in the last 24 hours.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Pain As Bad As You Can Imagine

5. Please rate your pain by marking the box beside the number that best describes your pain on the average.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Pain As Bad As You Can Imagine

6. Please rate your pain by marking the box beside the number that tells how much pain you have right now.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Pain As Bad As You Can Imagine

1903

Date: ___ / ___ / ___ (month) (day) (year)

Subject's Initials : _____

Study Subject #: _____

Study Name: _____

Protocol #: _____

PI: _____

Revision: 07/01/05

PLEASE USE BLACK INK PEN

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please mark the box below the percentage that most shows how much relief you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
☐ No Relief	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ Complete Relief

9. Mark the box beside the number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

☐0 Does Not Interfere ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Completely Interferes

B. Mood

☐0 Does Not Interfere ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Completely Interferes

C. Walking ability

☐0 Does Not Interfere ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Completely Interferes

D. Normal Work (includes both work outside the home and housework)

☐0 Does Not Interfere ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Completely Interferes

E. Relations with other people

☐0 Does Not Interfere ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Completely Interferes

F. Sleep

☐0 Does Not Interfere ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Completely Interferes

G. Enjoyment of life

☐0 Does Not Interfere ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Completely Interferes

Brief Fatigue Inventory

STUDY ID# _____ HOSPITAL # _____

Date: ____/____/____ Time: _____

Name _____ _____ _____

Last First Middle Initial

Throughout our lives, most of us have times when we feel very tired or fatigued. Have you felt unusually tired or fatigued in the last week? Yes ☐ No ☐

1. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your fatigue right NOW.

0 1 2 3 4 5 6 7 8 9 10
No Fatigue — As bad as you can imagine

2. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your USUAL level of fatigue during past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Fatigue — As bad as you can imagine

3. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your WORST level of fatigue during past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Fatigue — As bad as you can imagine

4. Circle the one number that describes how, during the past 24 hours, fatigue has interfered with your:

A. General activity
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely Interferes

B. Mood
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely Interferes

C. Walking ability
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely Interferes

D. Normal work (includes both work outside the home and daily chores)
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely Interferes

E. Relations with other people
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely Interferes

F. Enjoyment of life
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely Interferes

Please answer the following questions about how you feel about your body

1) Are you concerned about the appearance of some part(s) of your body which you consider especially unattractive?

Not at all concerned	Somewhat concerned	Moderately concerned	Very concerned	Extremely concerned
☐	☐	☐	☐	☐

What are these concerns? What specifically bothers you about the appearance of these body parts?

_____

2) If you are at least somewhat concerned, do these concerns preoccupy you? That is, you think about them a lot and they're hard to stop thinking about?

Not at all preoccupied	Somewhat preoccupied	Moderately preoccupied	Very preoccupied	Extremely preoccupied
☐	☐	☐	☐	☐

What effect has your preoccupation with your appearance had on your life?_____

_____

3) Has the physical effect of your disease often caused you a lot of distress or torment? How much?

Not at all distressed	Somewhat distressed	Moderately distressed	Very distressed	Extremely distressed
☐	☐	☐	☐	☐

4) Has the physical effect of your disease caused you impairment in social, occupational or other important areas of functioning? How much?

No limitation	Mild interference	Moderate, still manageable	Severe interference	Extremely incapacitating
☐	☐	☐	☐	☐

5) Has the physical effect of your disease significantly interfered with your social life? How much?

Never	Occasionally	Moderately often	Often	Very often
☐	☐	☐	☐	☐

6) Has the physical effect of your disease significantly interfered with your schoolwork, your job, or your ability to function in your role? How much?

Never	Occasionally	Moderately often	Often	Very often
☐	☐	☐	☐	☐

If so, how? _____

7) Do you ever avoid things because of your physical effect of your disease? How often?

Never	Occasionally	Moderately often	Often	Very often
☐	☐	☐	☐	☐

If so, what do you avoid? _____

PROMIS Item Bank v1.0 – Emotional Distress – Depression – Short Form 6a

Depression – Short Form 6a

Please respond to each question or statement by marking one box per row.

	In the past 7 days...	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
1	I felt worthless	☐	☐	☐	☐	☐
2	I felt helpless	☐	☐	☐	☐	☐
3	I felt depressed	☐	☐	☐	☐	☐
4	I felt hopeless	☐	☐	☐	☐	☐
5	I felt like a failure	☐	☐	☐	☐	☐
6	I felt unhappy	☐	☐	☐	☐	☐

LEVEL 2—Anxiety—Adult*

*PROMIS Emotional Distress—Anxiety—Short Form

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If the measure is being completed by an informant, what is your relationship with the individual? _____

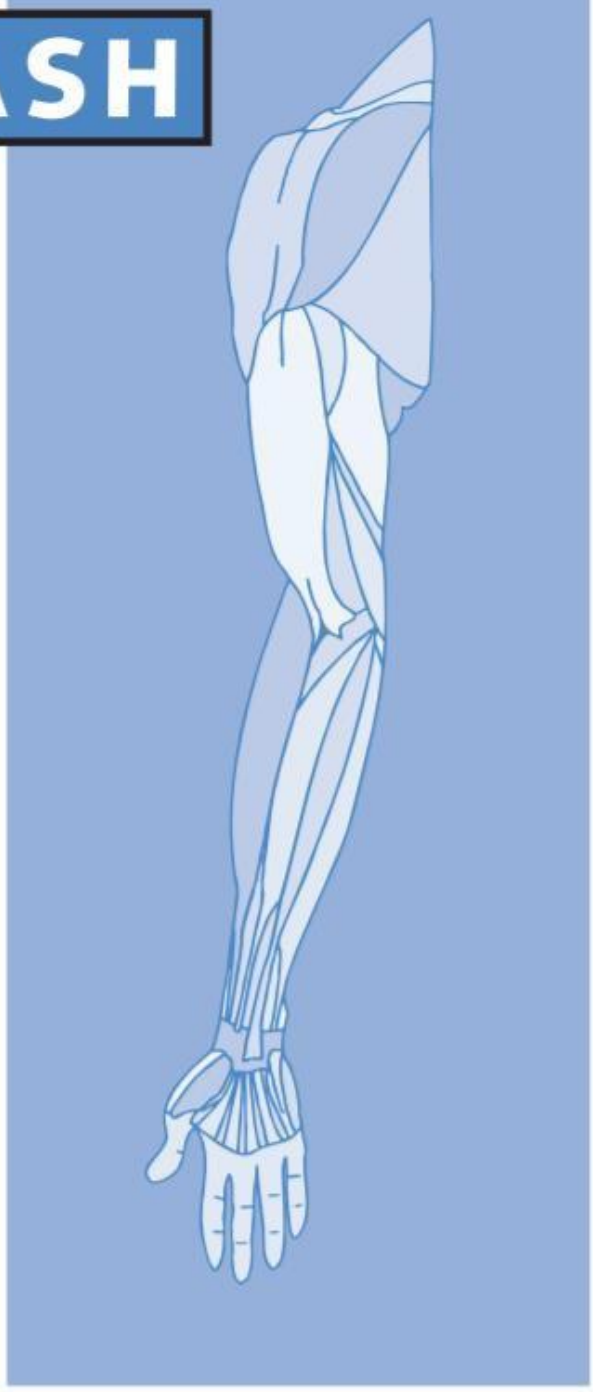
In a typical week, approximately how much time do you spend with the individual? _____hours/week

Instructions to patient: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (individual receiving care) have been bothered by "feeling nervous, anxious, frightened, worried, or on edge", "feeling panic or being frightened", and/or "avoiding situations that make you anxious" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							**Item Score**
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I felt fearful.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt anxious.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt worried.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I found it hard to focus on anything other than my anxiety.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt nervous.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	I felt uneasy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	I felt tense.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

DISABILITIES OF THE ARM, SHOULDER AND HAND

THE DASH



INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

DISABILITIES OF THE ARM, SHOULDER AND HAND

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

DISABILITIES OF THE ARM, SHOULDER AND HAND

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = $\left[\left(\frac{\text{sum of n responses}}{n}\right) - 1\right] \times 25$, where n is equal to the number of completed responses.

A DASH score may not be calculated if there are greater than 3 missing items.

DISABILITIES OF THE ARM, SHOULDER AND HAND

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including home-making if that is your main work role).

Please indicate what your job/work is:_____

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:_____

❑ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may <u>not</u> be calculated if there are any missing items.

Institute for Work & Health | Research Excellence Advancing Employee Health

How interested are you in receiving care to address sexual issues?	• Very interested • Somewhat interested • Not at all interested
How likely is it that you would come to see one of our colleagues to have sexual matters addressed?	• Very likely • Somewhat likely • Unlikely • Very unlikely
Have you recently sought advice or medical help for problems related to sexuality?	• Yes • No
If you have sought help for problems related to sexuality, how satisfied were you with the care you received?	• Very satisfied • Somewhat satisfied • Dissatisfied • Very dissatisfied
Would you be willing to be contacted if we develop a formal program to address sexual issues for women?	• Yes • No

Sexual Health Needs Assessment Questionnaire

FICA Tool	
F – Faith, Belief, Meaning	**Religious/Religiosity –** Pertains to one's beliefs, behaviors, values, rules for conduct, and rituals associated with a specific religious tradition or denomination (O'Brien, 1999). **Spirituality –** Generally, an "individual's attitude and beliefs related to transcendence (God) or to the nonmaterial forces of life and of nature…the dimension of a person that is concerned with ultimate ends and values" and meaning (O'Brien, 1982, p. 88; Taylor, 2006).
• Do you consider yourself spiritual or religious?	
• Do you have spiritual beliefs that help you cope with stress?	
• What gives your life meaning?	
I – Importance and Influence	
• What importance does your faith or belief have in your life?	
• On a scale of 0 (not important) to 5 (very important), how would you rate the importance of faith/belief in your life?	
• Have your beliefs influenced you in how you handle stress?	
• What role do your beliefs play in your health care decision making?	
C – Community	
• Are you a part of a spiritual or religious community?	
• Is this of support to you and how?	
• Is there a group of people you really love or who are important to you?	
A – Address in Care	**We have talked a lot about your spirituality and/or religious beliefs and how they may or may not be of help to you during your illness. How can your health care providers best support your spirituality?**
• How would you like your health care provider to use this information about your spirituality as they care for you?	

Work Productivity and Activity Impairment Questionnaire:
Specific Health Problem V2.0 (WPAI:SHP)

The following questions ask about the effect of your PROBLEM on your ability to work and perform regular activities. *Please fill in the blanks or circle a number, as indicated.*

1. Are you currently employed (working for pay)? _____ NO ___ YES
   If NO, check "NO" and skip to question 6.

The next questions are about the **past seven days**, not including today.

2. During the past seven days, how many hours did you miss from work because of problems associated with your PROBLEM? *Include hours you missed on sick days, times you went in late, left early, etc., because of your PROBLEM. Do not include time you missed to participate in this study.*

   _____ HOURS

3. During the past seven days, how many hours did you miss from work because of any other reason, such as vacation, holidays, time off to participate in this study?

   _____HOURS

4. During the past seven days, how many hours did you actually work?

   _____HOURS *(If "0", skip to question 6.)*

5. During the past seven days, how much did your PROBLEM affect your productivity <u>while you were working</u>?

Think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual. If PROBLEM affected your work only a little, choose a low number. Choose a high number if PROBLEM affected your work a great deal.

Consider only how much <u>PROBLEM</u> affected productivity <u>while you were working</u>.

PROBLEM had no effect on my work	0	1	2	3	4	5	6	7	8	9	10	PROBLEM completely prevented me from working

CIRCLE A NUMBER

6. During the past seven days, how much did your PROBLEM affect your ability to do your regular daily activities, other than work at a job?

By regular activities, we mean the usual activities you do, such as work around the house, shopping, childcare, exercising, studying, etc. Think about times you were limited in the amount or kind of activities you could do and times you accomplished less than you would like. If PROBLEM affected your activities only a little, choose a low number. Choose a high number if PROBLEM affected your activities a great deal.

Consider only how much <u>PROBLEM</u> affected your ability to do your regular daily activities, other than work at a job.

PROBLEM had no effect on my daily activities	0	1	2	3	4	5	6	7	8	9	10	PROBLEM completely prevented me from doing my daily activities

CIRCLE A NUMBER

WPAI:SHP V2.0 (US English)

Reilly MC, Zbrozek AS, Dukes E: The validity and reproducibility of a work productivity and activity impairment measure. PharmacoEconomics 1993; 4(5):353-365.

Quality of Life Scale/CANCER PATIENT/CANCER SURVIVOR

Directions: We are interested in knowing how your experience of having cancer affects your Quality of Life. Please answer all of the following questions based on your life **at this time.**

Please circle the number from 0 - 10 that best describe your experiences:

Physical Well Being

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. **Appetite changes**

no problem 0 1 2 3 4 5 6 7 8 9 10 **severe problem**

3. **Aches or pain**

no problem 0 1 2 3 4 5 6 7 8 9 10 **severe problem**

4. **Sleep changes**

no problem 0 1 2 3 4 5 6 7 8 9 10 **severe problem**

5. **Constipation**

no problem 0 1 2 3 4 5 6 7 8 9 10 **severe problem**

6. **Nausea**

no problem 0 1 2 3 4 5 6 7 8 9 10 **severe problem**

7. **Menstrual changes or fertility**

no problem 0 1 2 3 4 5 6 7 8 9 10 **severe problem**

8. Rate your **overall physical health**

extremely poor 0 1 2 3 4 5 6 7 8 9 10 **excellent**

Psychological Well Being Items

9. How difficult is it for you to **cope** today as a result of your disease and treatment?

not at all difficult	0	1	2	3	4	5	6	7	8	9	10	**very difficult**

10. How good is your **quality of life**?

extremely poor	0	1	2	3	4	5	6	7	8	9	10	**excellent**

11. How much **happiness** do you feel?

none at all	0	1	2	3	4	5	6	7	8	9	10	**a great deal**

12. Do you feel like you are **in control** of things in your life?

not at all	0	1	2	3	4	5	6	7	8	9	10	**completely**

13. How **satisfying** is your life?

not at all	0	1	2	3	4	5	6	7	8	9	10	**completely**

14. How is your present ability to **concentrate or to remember** things?

extremely poor	0	1	2	3	4	5	6	7	8	9	10	**excellent**

15. How **useful** do you feel?

not at all	0	1	2	3	4	5	6	7	8	9	10	**extremely**

16. Has your illness or treatment caused changes in your **appearance**?

not at all	0	1	2	3	4	5	6	7	8	9	10	**extremely**

17. Has your illness or treatment caused changes in your **self concept** (the way you see yourself)?

not at all	0	1	2	3	4	5	6	7	8	9	10	**extremely**

How distressing were the following aspects of your illness and treatment?

18. **Initial diagnosis**

not at all distressing	0	1	2	3	4	5	6	7	8	9	10	**very distressing**

19. **Cancer treatments** (i.e. chemotherapy, radiation, or surgery)

not at all distressing	0	1	2	3	4	5	6	7	8	9	10	**very distressing**

20. **Time since my treatment** was completed

not at all distressing	0	1	2	3	4	5	6	7	8	9	10	**very distressing**

21. How much **anxiety** do you have?

none at all	0	1	2	3	4	5	6	7	8	9	10	**a great deal**

22. How much **depression** do you have?

none at all	0	1	2	3	4	5	6	7	8	9	10	**a great deal**

To what extent are you <u>fearful</u> of:

23. **Future diagnostic tests**

no fear	0	1	2	3	4	5	6	7	8	9	10	**extreme fear**

24. **A second cancer**

no fear	0	1	2	3	4	5	6	7	8	9	10	**extreme fear**

25. **Recurrence** of your cancer

no fear	0	1	2	3	4	5	6	7	8	9	10	**extreme fear**

26. **Spreading (metastasis)** of your cancer

no fear	0	1	2	3	4	5	6	7	8	9	10	**extreme fear**

Social Concerns

27. How distressing has illness been for your **family**?

not at all 0 1 2 3 4 5 6 7 8 9 10 **a great deal**

28. Is the amount of **support** you receive from others sufficient to meet your needs?

not at all 0 1 2 3 4 5 6 7 8 9 10 **a great deal**

29. Is your continuing health care interfering with your **personal relationships**?

not at all 0 1 2 3 4 5 6 7 8 9 10 **a great deal**

30. Is your **sexuality** impacted by your illness?

not at all 0 1 2 3 4 5 6 7 8 9 10 **a great deal**

31. To what degree has your illness and treatment interfered with your **employment**?

no problem 0 1 2 3 4 5 6 7 8 9 10 **severe problem**

32. To what degree has your illness and treatment interfered with your **activities at home**?

no problem 0 1 2 3 4 5 6 7 8 9 10 **severe problem**

33. How much **isolation** do you feel is caused by your illness or treatment?

none 0 1 2 3 4 5 6 7 8 9 10 **a great deal**

34. How much **financial burden** have you incurred as a result of your illness and treatment?

none 0 1 2 3 4 5 6 7 8 9 10 **a great deal**

Spiritual Well Being

35. How important to you is your participation in **religious activities** such as praying, going to church?

not at all important	0	1	2	3	4	5	6	7	8	9	10	**very important**

36. How important to you are other **spiritual activities** such as meditation?

not at all important	0	1	2	3	4	5	6	7	8	9	10	**very important**

37. How much has your **spiritual life** changed as a result of cancer diagnosis?

less important	0	1	2	3	4	5	6	7	8	9	10	**more important**

38. How much **uncertainty** do you feel about your future?

not at all uncertain	0	1	2	3	4	5	6	7	8	9	10	**very uncertain**

39. 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**

40. 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**

41. How **hopeful** do you feel?

not at all hopeful	0	1	2	3	4	5	6	7	8	9	10	**very hopeful**

Insert NCCN Guidelines on cancer related fatigue